

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: WA

APPLICATION YEAR: 2005

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

To obtain a copy of the Assurances and Certifications, contact:

Jan Fleming, Director  
Washington State Department of Health  
Office of Maternal and Child Health  
Post Office Box 7835  
7211 Cleanwater Lane, Building 10  
Olympia, WA 98504-7835

Phone: (360) 236-3581  
Email: jan.fleming@doh.wa.gov

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

Two public forums were convened in fall of 2002 to secure input for this year's application. The first forum was held in Eastern Washington and the second was held in Western Washington. Participants included parents of children with special health care needs, representatives from LHJs, and other service providers.

Needs and concerns that were expressed included: reductions in state funding for child care for children with special health care needs; inadequate mental health services for pregnant and post partum women; need more parenting classes; elimination of Medicaid coverage for undocumented children; and care coordination and support to families with children with special health care needs.

These needs and concerns are consistent with on going feedback received through a variety of stakeholder groups that meet throughout the year.

*//2005/*

***Input for the MCH Block Grant application has been solicited from multiple existing stakeholder groups, including families and family organizations, as part of the process for our Five Year Needs Assessment. These groups are actively engaged with specific MCH sections and populations, and sometimes more than one population group, on a regular basis. They represent communities, universities, state agencies, local health departments, and other organizations. They are knowledgeable and articulate about MCH needs and emerging issues. Engaging them in the Five Year Needs Assessment process offers the opportunity for us to look toward the future and plan collaboratively and effectively.//2005//***



## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

Washington State encompasses over 66,000 square miles of the northwest corner of the United States. It is bordered north and south by British Columbia and Oregon, east and west by Idaho and the Pacific Ocean. The Cascade Mountains divide the state into distinct climatic areas. Western Washington, sandwiched between the Pacific Ocean and the Cascades, has an abundance of rain. The geographically larger area east of the Cascades (in the rain shadow) is much dryer than the western area.

While the average population density in the state in 2000 was 88.5 persons per square mile, and similar to the national rate, nearly 80 percent of Washington's population is concentrated west of the Cascade Mountains. The three most populous counties, King, Pierce and Snohomish are located on and prosper from Puget Sound. Another western county, Clark, gains economically from proximity to Portland, Oregon, while the city of Spokane and the county, in eastern Washington, are near enough to benefit from Coeur d'Alene, Idaho.

Geography, climate and economic resources influence Washington's population distribution. Population density ranges from 817 persons per square mile in King County to three persons per square mile in Garfield and Ferry counties.(1) There are 39 counties in Washington, each with its own local government. These counties form 35 independent local health jurisdictions (LHJs), which are funded with varying amounts of federal, state, and local dollars.

#### **Economy**

As a result of a combination of factors, Washington State continues to struggle with an economic slowdown. To the aftermath of the burst dot-com bubble and the decline of airframe demand, resulting in part from the events of September 11, 2001; has recently been added this nation's first case of "Mad Cow Disease," bovine spongiform encephalopathy (BSE), in Mabton, Washington. Prior to the BSE incident, in November 2003, the State's seasonally adjusted unemployment rate was 6.8 percent. Washington's unemployment rate still remains one of the highest in the nation. The unemployment rate for February 2004 was 6.1 percent compared to 5.6 percent nationally.(2)

Several years of economic doldrums, combined with spending constraints and spending limits from voter-approved initiatives have produced a continuing budget crisis for Washington. In the past, State revenue "surpluses" have been available to backfill revenue shortfalls faced by local governments. Continuing budget problems greatly reduce the State's capacity to subsidize local government revenue shortfalls, with the result that many local programs are struggling financially. Economic hard times also increase the need for public health services, so the current decrease in funding is having a major impact on local public health. As the economic and state fiscal crisis continues, future reductions in local public health are expected. Local health jurisdictions are currently being forced to reduce staff and programs.

#### **Population**

Washington's population continues to grow. The 2000 Census indicated the state's population was 5,894,121; an increase of 21.1 percent since the 1990 Census.(3) The Washington Office of Financial Management's (OFM) preliminary intercensal population estimate for the State in 2003 was 6,098,300.(4)

In the early 1990's, Washington's population grew by over 2 percent per year, nearly twice the national rate. In 2000, the State ranked seventh in the country in numerical population growth and tenth in percentage population growth since 1990, according to the 2000 Census.(5) However, from 1995 to 2000, growth slowed to an average of 1.3 percent per year. Since 2000, growth in Washington has averaged 1.1 percent per year. Since 1995, natural population increase (births minus deaths) has remained fairly constant, while net migration (people moving into the state versus people

moving out) has decreased from 68.3 in 1995 to an estimated 23.1 in 2003.(6) This decrease was most likely due to the strong national economy of 1990's and the increasingly poor economy in Washington in the past few years, resulting in fewer people looking for employment opportunities in Washington.(7)

## Race/Ethnicity in Washington State

The majority of Washington's population identifies itself as White and non-Hispanic. In the 2000 Census, 81.8 percent of Washington's population reported its race as White, 5.5 percent Asian, 3.2 percent Black, 1.6 percent American Indian or Alaskan Native, 0.4 percent Native Hawaiian and other Pacific Islander, and 3.9 percent Other. Individuals who reported two or more races accounted for 3.6 percent. Finally, 7.5 percent of the population reported Hispanic or Latino ethnicity.(8)

Although the majority of Washington's population remains White and non-Hispanic, the State's other race and ethnic minority populations increased rapidly in the last decade. Together, non-Whites and Hispanics in Washington increased from 13.2 percent of the overall population in 1990 to 21 percent (1,241,631) of the population in 2000. The State population of Asian and Pacific Islanders increased by 78 percent; Blacks 35 percent; and American Indians, Alaskan Natives, and Aleuts 29 percent.

The Hispanic population in Washington State has more than doubled since the 1990 Census, from 214,570 in 1990, to 441,509 in 2000. Counties with large proportions of Hispanics tend to be located in rural areas of eastern and central Washington. In Adams County, the Hispanic population rose from 32.8 percent in 1990 to 47.1 percent in 2000; Franklin County saw an increase from 30.2 percent to 46.7 percent; and Yakima County saw an increase from 23.9 percent to 35.9 percent. Large Hispanic populations also live in King, Pierce, and Snohomish counties. The majority (74.7 percent) of Hispanics in Washington are from Mexico, 20.6 percent are from "other countries" (Central and South America), 3.7 percent from Puerto Rico, and 1.0 percent from Cuba.(9) In 2000, there were approximately 289,000 migrant and seasonal farm workers and dependents living in Washington, who were primarily Hispanic. Migrant and seasonal farm workers are more likely to have low family incomes, face language barriers, and have limited transportation options. Most rely on Community and Migrant Health Centers (CMHC) for their health care.

Blacks and Asian/Pacific Islanders are predominantly located in urban areas west of the Cascades. Approximately 50 percent of each population resides in King County alone. There are also 29 federally recognized American Indian tribes throughout Washington with varying populations and land areas, and two more tribes seeking federal recognition.

## Languages

According to the 2000 Census, approximately 15 percent, or 168,000, of Washington's children age 5-17 speak a language other than English at home. Of these children, 43 percent speak Spanish, 29 percent speak Asian and Pacific Islander languages, 26 percent speak other Indo-European languages, and 4 percent speak other languages. A similar figure of 14 percent, or 512,000, of the adult population age 18-64 does not speak English at home. Of those who do not speak English at home, 88 percent of the children and 75 percent of the adults speak English "very well" or "well." Twelve percent of the children and 25 percent of the adults, speak English "not well" or "not at all".(10)

Approximately 40,700 Spanish-speaking students were enrolled in the English as a Second Language program in Washington State for the 1999-2000 school year. Other languages with high enrollments were Russian (5,500), Vietnamese (3,200), Ukrainian (2,900), Korean (1,800), Cambodian (1,400), and Tagalog (1,000).

## Age

In 2002, there were 79,003 resident births in Washington State. The Census 2000 population counts

show that almost 22 percent, or 1.29 million of the estimated 5.9 million people in Washington in 2000, were women of reproductive age (15-44 years). Nearly 29 percent, or 1.68 million, were children 19 and younger. Within both of these groups are over 125,000 women age 15 to 17. Adolescent pregnancy rates (ages 15-17) have declined in Washington from 57.9 per 1,000 women in 1990 to 30.9 per 1,000 women in 2002.(11) A State forecast predicts that over the next 30 years, as the children of baby boomers reach adulthood, the number of women of reproductive age will increase substantially. The school age population (5-17 years) is expected to remain stable through 2010 and then gradually increase. In 2003, there were an estimated 1,121,136 youngsters aged 5 to 17.(12)

## Urban/Rural

Seventy-two percent of population growth over the past decade has occurred in the western portion of the state, where the majority of the population lives. While there are many rural areas in western Washington, the most rural counties are located in eastern Washington. Rural county residents tend to have lower median household incomes, higher poverty rates, and higher unemployment rates. A recent review of health status indicators found some differences between the health status of rural and urban residents, though it is difficult to assess specifically whether the decreased health status is linked to rural location, isolation, or decreased access to care.(13)

## Poverty and Health Insurance

According to the 2002 Washington State Population Survey, an estimated 35.4 percent (574,389) of children in Washington were living below 200 percent of the Federal Poverty Level (FPL, \$18,392 for a family of four in 2002), compared to 33.4 percent in 2000. An estimated 17.5 percent (284,308) of the children were living below 100 percent of FPL and 11 percent (179,587) were living at or below 50 percent of FPL.(14)

Findings from the Washington State Population Survey administered in 2002 indicate the percent of Washington residents without insurance is increasing. Among the general population, 8.4 percent were uninsured in 2000 compared to 10.7 percent in 2002; a 27 percent increase. The percent of uninsured children increased almost 20 percent from 7.1 percent in 2000 to 8.6 percent in 2002, amounting to over 139,000 uninsured children in Washington.(15)

The Washington State Medical Assistance Administration (MAA) provides health care services to low income people in Washington, primarily through the federal/state Medicaid partnership. In 2002, Medicaid covered pregnant women up to 185 percent of the FPL and paid for prenatal care and deliveries for approximately 43 percent of state births.(16) The "Take Charge" program at MAA provides pre-pregnancy family planning for men and women with incomes at or below 200 percent FPL. The State Children's Health Insurance Program (SCHIP) provides health coverage for children of families with incomes from 200-250 percent of the FPL. Prior to enactment of SCHIP in 1997, Washington was one of only four states with Medicaid coverage at or above 200 percent FPL.

(1) Washington State Office of Financial Management, US Census 2000 Maps.

(2) US Department of Labor, Bureau of Labor Statistics

(3) Washington State Office of Financial Management, Population Forecasting Division, Census 2000 results show Washington's population increased by over 1 million during the 1990s, 12/28/2000.

(4) Washington State Office of Financial Management, 2003 State Data Book

(5) U.S. Census Bureau, Census 2000 Redistricting Data (P.L. 94-171) Summary File and 1990 Census, 4/02/2001.

(6) Washington State Data Book 2003, Components of Population Change Table.

(7) Washington State Office of Financial Management, Population Forecasting Division, Washington's Population Growth Continues to Slow, 6/30/2000.

(8) US Census Bureau, Census 2000, Table DP-1. Profile of General Demographic Characteristics: 2000.

(9) 1990 and 2000 Census, Office of Financial Management.

- (10) US Census Bureau, Census 2000 Supplementary Survey Summary Tables, Table PO35. Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over.
- (11) Washington State, Pregnancy and Induced Abortion Statistics 2002, Center for Health Statistics, December 2003.
- (12) Washington State Office of Financial Management. Forecast of the State Population by Age and Sex, 1990 to 2030.
- (13) Schueler V, Stuart B, Recent research and data on rural health in Washington State, Olympia, WA: 2000 October.
- (14) Data provided by Washington's Office of Financial Management.
- (15) Mounts TN. The Uninsured Population in Washington State. 2002 Washington State Population Survey Research Brief No 16. Washington State Office of Financial Management, November 2002.
- (16) Laurie Cawthon. Characteristics of Washington State Medicaid Women Who Gave Birth, DSHS Research and Data Analysis, 11/5/2003.

## B. AGENCY CAPACITY

Within the past year, OMCH started a planning process that began with a revision of the vision and mission statements of the office and creating guiding principles. This coming year, OMCH will continue this planning process by developing a five year plan, which will focus on how we carry out our work.

OMCH's new vision is "All children and families in Washington State are nurtured and have the information and assistance they need to reach optimal health." The revised mission is "The Office of Maternal and Child Health works to protect and improve the health of people in Washington, with a focus on women, infants, children, adolescents, and families." The guiding principles are listed below:

We strive to:

- \* Develop collaborative partnerships
- \* Promote a learning environment and ready access to information for decision-making
- \* Be innovative, flexible, and adaptable to a constantly changing environment
- \* Work as a team
- \* Value diversity
- \* Value the public's trust and demonstrate a commitment to excellence
- \* Communicate clearly, respectfully, and honestly
- \* Be responsive to communication from others
- \* Take responsibility for our actions and reactions
- \* Promote learning and success by sharing information, knowledge and skills
- \* Evaluate and improve our programs and services

We promote a health system that:

- \* Includes individuals and families as partners in decision making
- \* Includes a comprehensive array of available and accessible resources and services
- \* Offers services in or near the individual's/family's community
- \* Demonstrates the knowledge and skills to be effective with culturally diverse individuals and families
- \* Includes a workforce representing the diversity of Washington's population
- \* Commits to the health, safety, and well being of individuals, families, and communities.

*/2005/*

***The Office of Maternal and Child Health (OMCH) works to protect and improve the health of people in Washington State with a focus on women, infants, children, adolescents, and families. MCH Programs work in close partnership with state and local agencies and consumers to promote effective health policies and quality systems of care. MCH data is collected, analyzed, and shared with other agencies and organizations to assure sound decision-making around health care policies and practices. MCH program activities emphasize infrastructure-building and population-based activities through preventive health information and education messages to the public and to health providers, early identification of health***

**issues, referral and linkage to services, and coordination of services. Programs contract with 35 local health jurisdictions, community-based organizations, universities and hospitals, direct service providers, family organizations, and other agencies and organizations to address MCH priorities and state and national performance measures. //2005//**

The Office of Maternal and Child Health is responsible for administering the Title V Block Grant, the CDC Immunization Grant, and a variety of other federal grants pertinent to MCH priorities and performance measures.

State statutes relevant to Title V program authority and how they impact the Title V program remain the same as those outlined in pages 8-11 of the 1996 Block Grant Application.

Capacity for better understanding of cultural competence as an office and for staff has improved over the years due to continual participation in the division level Multi-Cultural workgroup. A number of staff assumed leadership positions in this group and all staff participate in initial and ongoing training.

The Office of Maternal Child Health addresses health disparities through the MCH Health Disparities Task Force. This group was created several years ago to specifically address health disparities in the MCH population. Each OMCH section develops goals and objectives to reduce health disparities for the population they serve. We are in the process of learning about and incorporating Culturally and Linguistically Appropriate Services (CLAS) created by the Office of Minority Health.

The Office of MCH is comprised of seven separate sections, each with a specific focus. Three sections in OMCH target the major Title V populations: Maternal and Infant Health, Child and Adolescent Health, and Children with Special Health Care Needs. The other sections focus on issues that encompass the entire MCH population: Genetics, CHILD Profile, Immunizations, and MCH Assessment. Following is a brief description of the basic role of each OMCH section. Funding is through a combination of sources including Title V, State General Funds, the CDC, and Title XIX.

#### Maternal and Infant Health (MIH)

MIH, comprised of 8.6 full time equivalents (FTEs) **//2005/ 10.45 FTEs //2005//**, works to improve birth outcomes by promoting quality health and support services for pregnant and post-partum women and their infants. This work is accomplished through training, education, assessment, and intervention and with a system of regional perinatal care services that include the availability of quality tertiary care for high-risk women and newborns. Other services are provided through a collaborative network of state, Local Health Jurisdictions (LHJs), and non-profit providers. This network provides confidential pregnancy testing (limited) and referral, maternity support services, child development, and parenting information and education.

#### Child and Adolescent Health (CAH)

CAH, with 14.7 FTEs **//2005/ 15 FTEs//2005//**, works to promote and protect the health and well-being of children, adolescents, and their families in the context of their communities through assessing child and adolescent health status, developing strategies to improve health status, and assuring preventive health services. Through its programs, CAH promotes the use of national guidelines for well child and adolescent screening and referral, family support and leadership, teen pregnancy prevention, youth development, population-based oral health programs, promotion of social emotional well-being and mental health, and child care health consultation.

#### CHILD Profile (CP)

This section includes 3 FTEs **//2005/ 5.05 FTEs //2005//**. The work is twofold: an Immunization Registry and health promotion for young children. These two components assure parents have information to assist and support them in making health care decisions about their children, providers have access to a repository of data to make immunization decisions, and that public health has the information needed to protect the public from vaccine preventable diseases. DOH contracts with Public Health-Seattle King County and the University of Washington (UW) information technology staff for primary CHILD Profile operations and is integrating the Immunization Registry into the work of

the DOH Immunization Program.

#### Children with Special Health Care Needs (CSHCN)

This program has a total of 8.5 FTEs **/2005/ 9.5 FTEs //2005//**. CSHCN promotes integrated systems of care that assure the population of children with special health care needs and their families the opportunity to achieve the healthiest life possible and to develop to their fullest potential. CSHCN staff provides leadership in addressing health system issues that impact this population; work with families and other leaders to influence priority setting, planning and policy development; and support community efforts in assessing the health and well-being of children with special health care needs and their families. This work is carried out through partnerships with other state-level agencies, contracted relationships with LHJs, private and non-profit agencies, the UW, Children's Hospital and Regional Medical Center, other tertiary care centers, and family organizations. These contracts and partnerships significantly extend CSHCN program capacity in the areas of policy development, assessment, quality assurance, and provider education.

#### Genetic Services

Genetic Services, with 5.0 FTEs **/2005/ 6.0 FTEs //2005//**, is focused on assuring high quality comprehensive genetic services throughout the state. This section also includes activities aimed at surveillance and intervention for secondary conditions affecting people with disabilities; FAS prevention; genetics education; technical assistance to the newborn screening program; and early promotion of hearing loss detection, diagnosis, and intervention.

#### Immunization Program (IP)

This program, with 19.7 FTEs **/2005/ 20 FTEs //2005//** and funding from the CDC and state, is committed to preventing the occurrence and transmission of childhood, adolescent, and adult vaccine-preventable diseases. The program provides leadership for an integrated and comprehensive immunization delivery system and universal vaccine access for all children less than 19 years of age. The IP expands public awareness of the need for immunizations throughout the life span and promotes community education, participation, and partnerships. The program has significant partnerships within the department including the Smallpox program, Communicable Disease and Epidemiology, CHILD Profile, Infectious Disease, and the Office of the Assistant Secretary. Additionally, this program has established partnerships with the American Academy of Pediatrics, a Vaccine Advisory Committee of expert physicians, a statewide coalition, and all local health jurisdictions.

#### MCH Assessment (MCHAS)

This section, with 9.9 FTEs **/2005/ 11.35 FTEs //2005//**, provides data, analysis, research, surveillance, and consultative support and management of all assessment activities within OMCH. Specific activities include leading the Five Year Needs Assessment process, performance measures and health indicator status reporting, administration and analysis of PRAMS data and development of data reports, collection and analysis of data from child death reviews, cluster investigations, birth defects and surveillance, and implementation of State Systems Development activities. MCHAS also designs and implements surveys and responds to data requests from the OMCH, other programs within DOH, LHJs, and other external stakeholders.

**/2005/**

#### **MCH Administration**

**This section has a total of 5.1 FTEs and provides administrative support to the sections of the Office of Maternal and Child Health by way of policy and fiscal development and oversight.**

**//2005//**

## **C. ORGANIZATIONAL STRUCTURE**

The Department of Health is located within the Executive Branch of state government, with the Secretary of Health reporting directly to the Governor. DOH includes five major divisions, one of which is Community and Family Health. The Office of Maternal and Child Health is one of three offices

within this division. In Washington State, the Children with Special Health Care Needs Program is part of the OMCH.

The Department, through the Office of the Assistant Secretary for Community and Family Health and the Office of Maternal and Child Health, is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V" (Section 509(b)). All programs funded by the Federal-State Block Grant partnership are included under this administration (Form 2, Line 8)."

For a Department of Health organization chart, go to the following internet link:  
<http://www.doh.wa.gov/Org/org.htm>

For a Division of Community and Family Health organization chart, go to the following internet link:  
<http://www.doh.wa.gov/cfh/CFHOrgChart.htm>

For an Office of Maternal and Child Health organization chart, see the attached file:  
[IIIC\\_OrganizationalStructure.pdf](#)

## **D. OTHER MCH CAPACITY**

The Office of Maternal and Child Health has a total of 73.2 FTEs ~~/2005/ 82.45 FTEs //2005//~~ with staff in a variety of specialty areas including: public health administration, public health nursing, children with special health care needs, obstetrics, perinatal care, adolescents, early childhood, health education, nutrition, genetics, immunizations, and psychology. OMCH also employs a parent of a child with special health care needs as a full-time family consultant for the CSHCN program. This individual works with staff on all CSHCN issues and plays an instrumental role in facilitating family consultation and participation within OMCH and at the local, regional, and state level.

The majority of staff are located in Olympia, Washington. The Genetics Services section is located in Kent, Washington near Seattle.

Following are brief biographical sketches of DOH senior management and managers within OMCH:

Mary Selecky has been the Secretary of DOH for five years. She is a political science and history graduate of the University of Pennsylvania and is the President of the Association of State and Territorial Health Officers (ASTHO). Prior to her appointment as Secretary of Health, Mary worked for 20 years as the Administrator of the NE Tri-County Health District in eastern Washington.

Dr. Maxine Hayes serves as the Health Officer for DOH. Prior to this, she was the Assistant Secretary of Community and Family Health, the Title V Director, and President of the Association of Maternal and Child Health Programs. Dr. Hayes is Associate Professor of Pediatrics at the University of Washington School of Medicine and is on the MCH faculty at the university's School of Public Health and Community Medicine.

Patty L. Hayes is the Title V Director and the Assistant Secretary for the Division of Community and Family Health. Prior to this, she was the Director of the DOH Office of Policy, Legislative and Constituent Relations, the Assistant Professor of the Master's Program in Leadership and Public Policy at St. Martin's College, and the Executive Director of the Nursing Care Quality Assurance Commission. In 2002, Patty L. Hayes was inducted to the Nursing Hall of Fame for Washington, sponsored by the Washington State Nurses Association.

Rick McNeely is the Acting Administrator for the Division of Community and Family Health. He has been with the Department of Health in a budget leadership role for over ten years. Rick received his bachelor's degree in accounting from Tuskegee University.

Jan Fleming is the Director of the Office of Maternal and Child Health. She is a registered nurse with a master of nursing degree and clinical specialty in children with special health care needs from the University of Washington. She has been with OMCH since 1990 and previously worked with children with special health care needs and their families in a university-affiliated program, in schools, public health departments, and as a Clinical Nurse Specialist in an early intervention program.

Sherilynn Casey, Manager of the Maternal and Infant Health section, has a master's degree in public administration from City University. She has been with OMCH for 20 years and was previously employed as a management and research analyst, including four years with the Medical Assistance Administration. She has considerable experience with contracts, interagency coordination, fiscal management, and maternal and infant health issues.

Debra Lochner Doyle, Manager of the Genetic Services section, has a bachelor of science degree in genetics from the University of Washington and a master of science degree in human genetics and genetic counseling from Sarah Lawrence College in New York. She is board certified by the American Board of Medical Genetics and the American Board of Genetic Counseling. She is also the past President of the National Society of Genetic Counselors and a founding member of the Coalition of State Genetic Coordinators.

Maria Nardella is the Manager of the Children with Special Health Care Needs section. Maria has 20 years experience in state CSHCN programs. She is a Registered Dietitian with a bachelor of science degree in nutrition from Cornell University and a master of arts in nutrition and mental retardation from the University of Washington, including clinical training at the university-affiliated program.

Nancy Reid, Manager of the Child and Adolescent Health section, has a master of social work degree from the University of Washington and a bachelor of arts degree from the University of Maryland. Prior to coming to OMCH, Nancy worked for 21 years managing statewide sexual assault, domestic violence, and alcohol and substance abuse programs at the Department of Social and Health Services.

Janna Bardi, Manager of the CHILD Profile section, has a master of public health degree in behavioral science and health education from the University of California, Los Angeles. She has experience in program analysis, policy development, systems development, inter- and intra-agency collaboration, and program evaluation. Janna is a 2003 scholar of the Northwest Public Health Leadership Institute.

Manager, Immunization Program. This position is vacant. Jan Fleming is the current Acting Manager of this program. Recruitment for a new manager was initiated at the completion of a planning process in June 2004.

Riley Peters, Manager of the MCH Assessment section, has a PhD in epidemiology from the University of Washington. He also holds a master in public administration with an emphasis in health administration from the University of Southern California. He has worked in local and state public health for over 20 years.

## **E. STATE AGENCY COORDINATION**

The following provides a brief description of the collaborative relationships the Office of Maternal and Child Health has developed within the OMCH, DOH, MAA (Title XIX), other state agencies, and other organizations. The outcomes of many of these collaborations are described in more detail in other portions of this document.

Washington State Board of Health (SBOH). The SBOH is an independent 10-member board appointed by the Governor. The Secretary of Health is a required member. The OMCH works with the SBOH on children's health issues including rules for newborn screening; prenatal screening; HIV

testing of pregnant women; immunizations; and hearing, vision, and scoliosis screening in schools. The OMCH also works with the SBOH on a legislatively mandated study on genetics.

## 1. OMCH Relationships with Other Offices Within the Washington State DOH

**Assessment.** MCHAS and other DOH epidemiology staff participate in a monthly department-wide Assessment Operations Group to set standards for all assessment functions within DOH, coordinate assessment activities, and facilitate communication across the Department. The MCH Assessment Manager sits on the AOG. This collaboration has resulted in improved coordination with the Center for Health Statistics and LHJ assessment staff.

**Community and Rural Health:** OMCH works with the DOH Office of Community and Rural Health on several issues, such as identifying unmet needs, women's health, obstetrical access, immunization rates, and domestic violence.

**The DOH Family Violence Prevention Workgroup:** This cross-agency workgroup is comprised of representatives from OMCH, Injury Prevention Program, Emergency Medical Services (EMS), and Family Planning. They meet monthly to coordinate activities, and plan, evaluate, and secure resources to decrease family violence.

**Environmental Health Clandestine Drug Lab (CDL) Program:** OMCH has an informal relationship with the Clandestine Drug Lab Clean-Up Office to respond to concerns at the local level about the safety and well being of children living in homes where methamphetamine is produced and used, and for their own safety when intervening. OMCH staff are working with a local coalition, including representation from CDL and law enforcement agencies, on possible ways to provide legal protection for drug-endangered children.

**Office of Infectious Disease and Reproductive Health (IDRH):** OMCH collaborates with the HIV/AIDS and Family Planning and Reproductive Health Programs (FPRH) in IDRH and other contractors through the MCH/HIV Workgroup. The focus of this workgroup is to develop effective policies and programs for HIV/AIDS prevention and care in the MCH populations and increase the number of medical providers who recommend HIV testing for all pregnant women. OMCH also works with FPRH to reduce unintended pregnancy and promote the Take Charge Program.

**Injury Prevention:** OMCH collaborates with the Injury Prevention Program and partially funds data collection and reporting intentional and unintentional on injuries, youth suicide, and family violence.

**Oral Health:** The OMCH Oral Health Program collaborates with the DOH Environmental Health Division, Epidemiology Program, Office of Health Promotion, Office of Community and Rural Health, and HIV/AIDS Program to enhance preventive oral health care and address unmet needs. OMCH also works with the Office of Drinking Water on fluoridation. The Maternity Support Services Program (MSS) educates providers regarding pregnancy and oral health and makes educational materials available to women on Medicaid.

**Healthy Child Care Washington (HCCW):** HCCW works with the Division of Environmental Health, Immunizations Program, CHILD Profile, Bright Futures, Parent Education/Family Support, and Child Death Review (CDR) teams related to SIDS prevention and oral health.

**Tobacco Control and Prevention Program (TCPP):** OMCH continues to work closely with TCPP on maternal and infant health issues. The TCPP program funded development and training for the MSS tobacco cessation project, and worked with OMCH staff to successfully advocate for Medicaid coverage of smoking cessation treatment for pregnant women. The TCPP contributes funds to the Healthy Mothers Healthy Babies (HMHB) toll-free line, which now asks callers about tobacco use and includes Tobacco Quit Line information in their prenatal and child health education packets. The TCPP is also involved in developing the Healthy Youth Survey (HYS) and provides major funding for this survey. The TCPP works closely with Pregnancy Risk Assessment Monitoring System (PRAMS)

by helping to fund the survey and by providing guidance on tobacco-related survey questions and analysis.

WIC: OMCH collaborates with the WIC program to promote breast-feeding, exchange data, enhance referrals, address access to care issues between WIC and First Steps, coordinate coverage for special formulas for children covered by Medicaid, and provide cross-training. OMCH provides training and materials to WIC program staff on methods for identifying and intervening with victims of domestic violence and child abuse, and promoting good oral health practices. OMCH also collaborates with WIC through a contract with HMHB. In 2003, staff at HMHB responded to 20,234 potential or enrolled WIC clients. MIH and WIC have collaborated to revise the parent education booklet entitled, "Nine Months to Get Ready", which is used for client education by WIC and MSS providers. Given federal requirements that WIC assess DtaP immunization completion, the Immunization Program and CHILD Profile are working with WIC to determine how to use the CHILD Profile Immunization Registry to fulfill this requirement and enhance immunization rates.

Women's Health Resource Network (WHRN): WHRN is a forum for department wide input and response to current and emerging women's health issues and service gaps including: data on women's health, policy related to program services, quality assurance and standards development, and changes in the health care system. The goal of the WHRN is to assist DOH in building state and local capacity to address the needs of women and their health concerns throughout their lives. The WHRN includes representatives from 16 Community and Family Health and Environmental Health programs.

## 2. OMCH Relationships with Local Health Jurisdictions (LHJs)

In Washington State, OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. OMCH program staff work closely with LHJs to oversee contract activities and provide consultation and technical assistance. OMCH administrators and staff meet regularly with the Nursing Directors of LHJs, and with other local OMCH staff through quarterly MCH Regional meetings. Some of the activities provided by LHJs are described at the end of this document. The OMCH provides technical assistance and data support for the local CDR teams throughout the state.

In 2002, a small increase in MCH Block Grant funds prompted OMCH to update a funding formula for LHJs. Eight LHJs received a small increase in funding in 2003 to enhance MCH services at the community level for the first time in nearly 10 years.

## 3. OMCH Relationships with Department of Social and Health Services (DSHS)

DOH maintains close relationships with DSHS programs to best serve our similar population groups. The agencies collaborate to maximize federal administrative match, build on the strengths of each department to promote the best outcomes for clients, generate and utilize data needed by both agencies, provide coordinated program services for clients, and provide complementary services and avoid duplication.

Medical Assistance Administration (MAA): An interagency agreement between MAA and OMCH has existed for 14 years. Partnerships between OMCH and MAA have developed with the mutual goal of assuring quality health services for pregnant women, infants, children, and adolescents served by Medicaid.

OMCH staff participate on the Medicaid External Quality Review Organization Contract committee (EQRO), the MAA Early Periodic Screening Diagnosis and Treatment (EPSDT) Improvement Committee, and the MAA Immunization Partnership Committee.

MAA provides administrative match for PRAMS activities not covered by the CDC grant. PRAMS data are stratified by Medicaid recipient status and used by the First Steps program to evaluate the effectiveness of program services.

CHILD Profile's partnership with MAA resulted in matching funds for CHILD Profile activities, data sharing agreements, MAA participation in developing the health promotion materials for parents, and MAA participation in the CHILD Profile Advisory Group. MAA and CHILD Profile are working jointly to maintain and expand partnerships with the state's health plans.

The CSHCN Section staff work with MAA to improve access and quality of health services for children with special health care needs through CSHCN Communication Network meetings, implementing quality assurance measures (using the survey screener developed by FACCT in the 2002 CAHPS survey), participating in the MAA interagency Disease Management Workgroup, and sharing data for Title V children in Medicaid managed care. MAA and CSHCN have also worked closely to share information about undocumented children who were covered by state-funded Medicaid programs until September 30, 2002 when the state Legislature discontinued this funding. While a coverage option was provided through the Basic Health Plan for this population, all costs will not be covered and a premium is required.

The Immunization Program works extensively with MAA on the Vaccines for Children Program (VFC) to ensure VFC-qualified children receive adequate immunizations.

OMCH provides state funding match for Medicaid prenatal genetic counseling services. OMCH staff oversee the program, and work with MAA to ensure that up-to-date billing instructions are in place. Medicaid also covers genetic counseling services for new parents up to 90 days after birth.

MAA participates on the statewide Perinatal Advisory Committee (PAC) and provides administrative match for the Regional Perinatal programs throughout the state. MAA also provides administrative match for the University of Washington (UW) School of Nursing contract that provides MCH-related training to public health nurses, First Steps providers, and others in local communities.

Medicaid Dental Program: The OMCH Oral Health Program collaborates with the Office of Medical Assistance on access to dental services for children receiving Medicaid services. OMCH and MAA both participate on two statewide oral health coalitions and meet together regularly on the Access to Baby and Child Dentistry (ABCD) Initiative and other access issues.

Division of Alcohol and Substance Abuse (DASA): OMCH actively participates in the oversight committee for developing, implementing, and evaluating a comprehensive treatment program for chemically dependent pregnant or parenting women and their young children. OMCH meets regularly with the Regional Perinatal Program drug screening staff leads and DASA staff to facilitate and provide technical assistance.

Children's Administration (CA): OMCH works with CA, which has historically included Child Protective Services (CPS), Child Care, Foster Care and other offices, on subjects of joint concern, such as chemically dependent pregnant women, child maltreatment, and Child Death Review.

Mental Health Division (MHD): The OMCH Mental Health Workgroup collaborates with the MHD to identify services, available data and possible gaps. CSHCN continues to provide the MHD with data to comply with the Center for Medicaid and Medicare Services (CMS, formerly HCFA) requirements for the Medicaid 1915B Waiver. This information provides the means to identify the number of children with special health care needs served by both Title V and the MHD. DOH is represented by OMCH staff on the DSHS Child, Youth and Family Mental Health Subcommittee.

Disability Determination Service (DDS) and Social Security Administration (SSA): The CSHCN program maintains a Memorandum of Agreement with DDS in order to provide information to families of children under the age of 16 who apply for SSI. DDS provides data files of all SSI applicants up to age 16 to the CSHCN program on a quarterly basis. Local CSHCN Coordinators contact families to inform them of local programs and services.

Division of Developmental Disabilities' Infant Toddler Early Intervention Program (ITEIP): OMCH is an active participant in coordinating efforts to implement Part C of the Individuals with Disabilities Education Act (IDEA). Through an Interagency Agreement with DSHS, the Department of Community Trade and Economic Development (DCTED), the Department of Services for the Blind, and Office of Superintendent of Public Instruction (OSPI); DOH works proactively with these partners to assure a comprehensive statewide system of early intervention services for eligible infants and toddlers (birth to three years) with disabilities and their families.

Division of Vocational Rehabilitation (DVR): Through the Adolescent Health Transition Project's (AHTP) contract with the University of Washington, health transition materials are provided at vocational fairs and conferences, and vocational counselors at DVR receive ongoing informational materials from the Project.

Office of Procedures and Policy: This DSHS program participates on the Perinatal Partnership Against Domestic Violence (PPADV). The PPADV reviews training materials, provides training and marketing of the PPADV curriculum, locates funding, and promotes awareness of domestic violence in the perinatal period. The PPADV has recently expanded its partnerships and includes multiple organizations.

Family Policy Council: The FPC includes representatives from five state agencies: DSHS, the Employment Security Department (ESD), OSPI, DCTED, and DOH. The Council focuses on family policy issues and reforming the service delivery system via the oversight of 53 local grassroots organizations called Public Health and Safety Networks. The DOH Health Officer, Maxine Hayes, is the co-chair of the Council.

#### 4. OMCH Relationships with the Office of Superintendent of Public Instruction

OMCH maintains a collaborative partnership with OSPI through a number of programmatic efforts. The Immunization Program works with OSPI's Health Services Supervisor on issues involving immunization requirements for school entry. The CSHCN Program works with OSPI to identify appropriate health outcome measures for children with special health care needs and select diagnostic codes to include in the "Student Health Manager" software currently being used in approximately half of the school districts in the state. OSPI participates on OMCH's Birth Defects Surveillance Advisory Board. OMCH also participates on an interagency team called STEPS (Sequenced Transition for Education in Public Schools) that addresses transition issues for children birth to school age. School Nurse Corps supervisors participate in MCH Regional meetings. Representatives from OSPI, CTED, DSHS, and the Family Policy Council (FPC) make up the joint Healthy Youth Survey planning committee. These same organizations, along with the Attorney General's Office, are members of the Washington State Partnership for Youth (WSPY). The purpose of WSPY is to develop a plan for improving adolescent health in Washington State.

#### 5. Hospitals And Other Specialized Services

Children's Hospital and Regional Medical Center (CHRMC): OMCH works with CHRMC through a contract with the Center for Children with Special Needs (CCSN) to provide data and information to families, providers, and policy makers regarding health issues for children with special health care needs and their families. The Genetic Services section also contracts with CHRMC to provide technical assistance to birthing hospitals in Washington that are initiating or already conducting Universal Newborn Hearing Screening.

Mary Bridge Children's Hospital and Health Center (MBCH): MBCH assists CSHCN in developing and disseminating guidelines to primary care providers for the care of high-risk infants as part of their discharge plan. Additionally, MBCH is the site of one of 14 MCH supported neurodevelopmental centers (NDCs) and the Maxillofacial Review Team for southwest Washington.

Regional Genetics Clinics: Six regional genetics clinics are located throughout the state and are

funded to provide clinical genetic services for the MCH population as well as provide educational outreach to the communities. Data generated by the regional genetic clinics are used for program planning and policy development.

**Regional Perinatal Programs:** Through contracts with OMCH, four regional perinatal programs provide consultation and training to health care providers on specialized care for high-risk pregnant women and neonates. The statewide Perinatal Advisory Committee, staffed by OMCH, brings together representatives from tertiary care centers, professional organizations, consumer groups, and state agencies to review and assess perinatal health issues and assist in developing policies and practices to improve perinatal outcomes.

**Community Health Clinics (CHC):** CHCs play a major role in providing access to direct health services as LHJs continue to move toward core public health functions. Most CHCs are also First Steps MSS providers and participate in First Steps education updates sponsored by OMCH and MAA. Community Health Clinic Dental Clinics participate with the Oral Health Program to collaborate on community-based preventive oral health programs such as school sealants and as a referral base for WIC and Headstart Children.

**Neurodevelopmental Centers:** Fourteen NDCs are supported in part by MCH funding to maintain the capacity to provide evaluation, diagnosis, coordinated treatment planning, and specialized therapy to children birth to three years of age with a variety of developmental or neurodevelopmental conditions. Data generated from these NDCs contribute to a yearly statewide count of infants and toddlers enrolled in Washington State public early intervention services and to CSHCN section assessment data.

**Native American Tribes:** OMCH works with the DOH tribal liaison to explore ways to expand and improve communication with tribes in Washington State. Specific actions include working with the American Indian Health Commission, expanded use of the DOH Tribal Connections website, and utilizing expanded tribal email contact lists for dissemination of information.

**Universities and Libraries:** DOH collaborates with the UW in a project using the State Capacity Grant for Prevention of Secondary Disabilities. This project is supported by a cooperative agreement with the Centers for Disease Control and Prevention to assess the types and prevalence of secondary disabilities and form local advisory councils to promote a public awareness campaign and implement strategies to prevent secondary disabilities.

OMCH contracts with several programs within the UW Clinical Training Unit's Center on Human Development and Disability (CHDD) through funds from an MCHB Leadership Education for Neurodevelopmental Disabilities (LEND) grant. These contracts extend and enhance MCH priorities in the areas of CHILD Profile, nutrition, high-risk infants and children, medical home, and emotional behavior in very young children.

CAH works with the UW School of Education, Early Childhood and Teen Telecommunications Network to foster leadership on issues of parents and teens and pre-teens at the state and local levels.

In addition to coordinating work with universities, OMCH contracts for services with the Washington State Library to provide books of interest to families with children with special health care needs via the public library system.

## 6. OMCH Relationships with Other Agencies and Programs

**Managed Care Plans:** CSHCN staff, in partnership with MAA and LHJs, continue to work with Medicaid managed care plans to meet requirements of the CMS 1915B waiver requiring MAA to identify, track, and serve children in managed care who are also served by Title V, and to allow families to request an exemption from managed care. Plan representatives have become a part of the

bi-monthly CSHCN Communication Network meetings. The CSHCN Program is also working with managed care plans to identify practical ways for providers to develop and provide medical homes for all children.

Parent Peer Support Networks: OMCH supports the Washington State Fathers Network (WSFN) in providing information, outreach, and support to fathers of children with special health care needs as well as consultation to the CSHCN Program and other state and local organizations. Washington State Parent-to-Parent (WSP2P), also supported through an OMCH contract, provides information, outreach, and emotional support to families who have children with special health care needs; local and state level training to assist parents in accessing services; and consultation to the CSHCN Program. Both organizations have planned and successfully provided outreach to racially and ethnically diverse families.

Healthy Mothers Healthy Babies (HMHB): OMCH contracts with HMHB toll-free telephone line for consumer information and referral for maternity care and other maternal and child health issues. The ASK line (Answers for Special Kids) addresses issues related to children with special health care needs. OMCH staff convene and facilitate a team approach to managing this contract to assure coordination among OMCH, FPRH, WIC, TCPP, DASA, and MAA programs related to HMHB activities.

## **F. HEALTH SYSTEMS CAPACITY INDICATORS**

See Forms 17, 18, and 19.

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

See Form 14 for a listing of the ten MCH population priorities that were described in detail in the 2000 Five Year Needs Assessment. This year, OMCH completed an interim needs assessment, which describes updates on these priorities. See section XA. This interim needs assessment and numerous other assessment activities, including public comment, indicate that these priorities continue to be the priorities for MCH population in Washington State. In most cases, the needs for these priorities are more pronounced than they were in 2000 due to the downturn in the economy.

The Office of Maternal and Child Health has begun the comprehensive five-year needs assessment for 2005. This effort is being coordinated with the development of a five-year plan for OMCH, which includes an assessment of the priorities and an evaluation of how we do our work.

A detailed description of OMCH's work on the national and state performance measures are provided in this section under items, "C. National Performance Measures," and "D. State Performance Measures."

### **B. STATE PRIORITIES**

The following summarizes the relationship between Washington State's OMCH priorities and the state and national performance measures, outcome measures, and health systems capacity indicators.

Improving access to comprehensive prenatal care.

NPM 15,17,18

SPM 3,6,8

OM 1-5

HSCI 4,9A

Improving oral health status and access to oral health care services.

NPM 9

HSCI 9A

Improving the coordination of services for children with special health care needs.

NPM 2,3,4,5,6,7

SPM 4

HSCI 1, 8, 9A

Improving early identification, diagnosis and intervention services and coordination of services.

NPM 1,7,12,13,14

SPM 7, 8, 10

HSCI 2, 3, 5, 6, 7, 8, 9A

Decreasing family violence.

SPM 6

HSCI 9A

Decreasing unintended pregnancy and teenage pregnancy.

NPM 8

SPM 1

HSCI9A

Improving mental health status.

NPM 16

SPM 7

HSCI 9A

Ensuring surveillance capacity for children with special health care needs.

SPM 4

HSCI 9A

Decreasing tobacco use.

SPM 2, 5, 8

HSCI 9A, 9B

Improving nutritional status.

NPM 11

SPM 9

HSCI 9A, 9C

Two other performance / outcome measures (NPM10 and OM 6) while not directly addressed in the MCH priorities are addressed by OMCH through partnership and collaboration with our partners in injury prevention.

Capability and resource capacity is described in the section "II B. Agency Capacity,"

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

### a. Last Year's Accomplishments

As recommended by the State Board of Health, a budget was developed and submitted to the legislature to incorporate the Newborn Screening Advisory Committee's recommendations for expanded newborn screening. The disorders proposed for addition were biotinidase deficiency, galactosemia, homocystinuria, medium chain acyl co-A dehydrogenase deficiency (MCADD), maple syrup urine disease (MSUD), and early hearing loss. Following funding approval by the legislature of the dried blood spot screening, the DOH worked with the SBOH to draft the revised rules (Chapter 246-650 WAC) and solicit public input in preparation for formal adoption. The SBOH elected not to mandate newborn hearing screening at the time. However, the legislature allocated State General Funds to assist with voluntary efforts by hospitals, and to support the tracking and surveillance of screening and follow-up.

CHILD Profile developed and initiated mailing the Health and Development Record that includes a message to encourage parents to talk with their provider about health screenings and provides a central area to record screenings, such as: 2nd PKU, hearing screening, vision, and lead screening. The Health and Development Record is distributed as part of the postpartum packet that arrives four to six weeks after a child is born. This mailing is sent to at least 90 percent of the annual birth population of approximately 80,000. (Fig 4a, NPM 1, Act. 3)

### b. Current Activities

The SBOH adopted the revised dried blood spot regulations at their regular meeting on October 15, 2003 and DOH began developing an implementation plan for the expanded screening. Screening for biotinidase deficiency and galactosemia was added to the mandatory panel of disorders on January 1, 2004. We are currently gearing up to implement screening for the final three disorders (homocystinuria, MCAD deficiency, and MSUD) on June 1, 2004. This involves using the state-of-the-art tandem mass spectrometry where multiple disorders can be detected using one blood spot. The equipment has been installed, staff is training, data systems are being updated, laboratory procedures and follow-up protocols are being

developed, and disease-specific educational materials for providers and parents are being created. Also, to help refine the diagnosis and clinical prognosis of galactosemia and MCAD deficiency, we are implementing real-time PCR in the Newborn Screening Laboratory.

We will be working with the SBOH to reconvene the Newborn Screening Advisory Committee to further consider adding cystic fibrosis to the panel and expanding use of tandem mass spectrometry.

CHILD Profile continued mailing the Health and Development Record that includes a message to encourage parents to talk with their provider about health screenings and provides a central area to record screenings, such as: PKU, hearing screening, vision, and lead screening. The Health and Development Record is distributed in the postpartum packet that arrives four to six weeks after a child is born. This mailing is sent to at least 90 percent of the annual birth population of approximately 80,000. (Fig 4a, NPM 1, Act. 3)

### c. Plan for the Coming Year

Following the Newborn Screening Advisory Committee meetings, we will summarize recommendations for consideration by the SBOH. Additional work in this area will depend on the nature of the committee's recommendations and the board's response.

Also, during this year we will continue to expand and refine our screening protocols, particularly for the most recent additions. We will make necessary adjustments and revisions based on our experience and that of other newborn screening programs.

CHILD Profile will revise and continue distributing the Health and Development Record as part of the postpartum packet, sent to Washington State parents 4-6 weeks after the birth of their child. (Fig. 4a, NPM 1, Act. 3)

*Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

### a. Last Year's Accomplishments

The CSHCN Program contracted with the CCSN at CHRMC to analyze the National CSHCN Survey. Baseline percent was calculated in 2003 and target percent for improvement was determined using the National CSHCN Survey. Activities to increase percentages were acknowledged and additional strategies developed. (Fig. 4a, NPM 2, Act. 1)

The CSHCN Program continued to provide leadership for inclusion of the family perspective in CSHCN policy and program development, and served as a statewide resource for promoting quality, integrated systems of care for children with special health care needs and their families. The CSHCN Program Family Consultant developed partnerships and worked closely with cross-agency and community organizations, including the Washington Integrated Services Enhancement (WISE) Grant Family Advisory Network (FAN), Washington Family to Family Network (WFFN), Family Voices, Infant Toddler Early Intervention Program (ITEIP), Washington State Fathers Network (WSFN), Washington State Parent to Parent (WSP2P), Ethnic Outreach Coordinator Program, Family Leadership Team, and other family support programs.

The WISE Grant hosted "Getting to the Heart of Family Centered Care for Children with Special Health Care Needs: Building Family Professional Partnerships Using a Cross Cultural

Approach" in early 2003, bringing together policy partners from around the state. Throughout the year, ten FAN parents received ongoing leadership training and mentoring, while they participated on WISE Grant committees. The Medical Home Leadership Network (MHLN) parent members were provided with leadership and partnership training through outreach conducted by the Medical Home Parent Consultant, in collaboration with the CSHCN Family Consultant.

Family organizations continued to be represented at the bi-monthly Communication Network. Family Voices was represented at a special forum to enhance knowledge of federal activities currently underway impacting children with special needs and their families at the January 2003 meeting of this group.

Parent participation continued as members of a network of feeding teams and as participants at annual workshops supported through a contract with CHDD at the UW. Tube feeding workshops with providers and caregivers occurred in February, April, and June 2003. (Fig. 4a, NPM 2, Act. 2)

## b. Current Activities

Through the contract with CHRMC, a CSHCN "Road Show" was developed using Washington state data from the National CSHCN Survey. The Road Show was presented several times to different local health agencies, parent organizations, health plans, and other stakeholders beginning in November and continuing to the present time. Discussions with these groups helped prioritize further analyses, identify what information was missing, and determined how the results of the survey can be used and disseminated with our partners. More information about how the families were interviewed and how the data directly impacts services for families were requested.

The Road Shows also provided a means to obtain input in identifying CSHCN priorities for the MCH 5 Year Needs Assessment from parent leaders, community health and others. (Fig. 4a, NPM 2, Act. 1)

The Program's Family Consultant is key in providing leadership for inclusion of the family perspective in CSHCN policy and program development. In late 2003, the MHLN and the CSHCN Program/WISE Grant collaboratively hosted a leadership training called "Taking a Leadership Role to Create Family-Professional Partnerships in Washington State." The audience included a wide spectrum of cross agency and community based parent leaders working on WISE Grant integration and health systems development at the state and local levels.

FAN parents took on increasingly responsible leadership roles as committee leads and facilitators for the WISE grant . The CSHCN Program developed a Family Leadership Plan, which serves as a template for a Statewide Family Leadership Plan developed collaboratively with the WFFN and CCSN. The CSHCN Program has assisted in developing cross agency partnership linkages on the Healthy Mothers Healthy Babies Answers for Special Kids Toll-free Line (ASK Line) website, and facilitated the representation of fathers on ASK Line promotional materials.

The CSHCN Communication Network continues to involve parent organizations as participants. The current year's meetings have focus topics of mental health, respite care, and serving culturally diverse families; all panels include at least one family member.

Parent participation as members of a network of feeding teams continues to be supported through a contract with the CHDD at the UW. All local contractors provide care coordination with parent involvement. They work closely with community early intervention programs to assure integrated services. (Fig. 4a, NPM 2, Act. 2)

### c. Plan for the Coming Year

The contract with CHRMC will create a data publication that provides a comprehensive picture of children with special health care needs both at the local level and in Washington State, using the National CSHCN Survey, county profiles, and results of other assessment activities. (Fig 4a, NPM2, Act. 1)

At the Fall 2004 Family Leadership Institute, parents will attend a variety of leadership sessions, including a workshop on data and utilizing the National CSHCN Survey. During this session, the CSHCN Program will have the opportunity to share the Washington State results and identify additional methods to increase the percentage of parents who partner in decision making at all levels and are satisfied with the services they receive, for the next National CSHCN Survey in 2005.

The CSHCN Program and the Program's Family Consultant will continue to promote inclusion of the family perspective in all programs in MCH as program policies are developed. Integrated, collaborative approaches to sharing information and resources will continue to be explored and promoted through WISE Grant committees, the FAN, WFFN. Work with contractors such as the ASK Line, Parent to Parent, Fathers Network, MHLN, AHTP, and the Center for Children with Special Needs will include specific language to include parents' participation and perspectives. The Statewide Family Leadership Plan will be introduced to partners, and in-service trainings will be provided in conjunction with training on "Practical Tips: Involving Family Consultants in Policy and Program Development."

Parent involvement as regular participants and as special presenters will continue, and new parent partners will be included as possible in the Communication Network meetings.

A network of community-based feeding teams with parents as members will continue to be supported through a contract with the UW. Guidelines on the development of community-based feeding teams will be revised and posted electronically to assist new communities in starting a team. (Fig. 4a, NPM 2, Act. 2)

*Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

### a. Last Year's Accomplishments

Through the CHRMC contract a baseline percent for this performance measure was calculated in spring 2003 and target percentages for improvement are being determined. Activities to increase that percentage were acknowledged and additional strategies developed. CCSN replicated and expanded the analysis for the 2002 Medical Assistance Administration's child-specific portion of the Consumer Assessment Health Plan Survey (CAHPS). (Fig. 4a, NPM 3, Act. 1)

The CSHCN Program took a lead role with Medical Home Leadership Network (MHLN) and other Medical Home State Plan partners to develop and evaluate the strategies implemented in the state in the medical home grant from MCHB which ended in March 2004.

Focus increased on medical homes for youth within the Adolescent Health Transition Project (AHTP), and staff linkages between medical home and adolescent health were strengthened. A medical home in-service was presented to the Washington State Fathers Network Advisory Board, and medical home teams were included in the parent-professional partnership training in early 2003.

In late spring, all CSHCN Coordinators were provided with a Medical Home Tool Kit developed jointly between MHLN and CCSN. They were encouraged to use it in outreach to physicians or other health care providers in their community. The kit contains resource information for both families and providers. (Fig. 4a, NPM 3, Act. 2)

The CSHCN Program continued to support three regional multidisciplinary Maxillofacial Review Teams across the state to coordinate care for infants and children born with oral facial defects, such as cleft lip and cleft palate. Local partners for these Teams include two LHJs, MBCH, and CHRMC, private sector medical specialists, and families.

#### b. Current Activities

The CSHCN program worked with our contractor, CHRMC, to analyze the Washington state data from the National CSHCN Survey and prepared the information for the CSHCN "Road Show". Statewide meetings were held for staff from local health, parent organizations, health plans, and other stakeholders. Feedback from these groups helped prioritize further analyses, identify missing information, and determine how the results can be used and disseminated. In support of the medical home concept, these groups cited needs for more information about access issues, especially to specialty providers and to mental health services, since these would be better addressed in a medical home environment.

Additional data sources include the CHIF automated data system to provide a percentage of children with special needs who are considered as having a medical home and are served by their community-based CSHCN programs. (Fig. 4a, NPM 3, Act. 1).

The CSHCN program continues to support MHLN, MBCH, AHTP, and CHRMC in developing and piloting their medical home initiatives and projects. The CSHCN program is providing ongoing leadership training and support to implement community-based initiatives.

Community resource bulletin boards in physician offices were reviewed by the MHLN Parent Consultant. A report on the different options, barriers, and recommendations was developed to serve as a planning guide for developing a system of maintaining current information about Medical Homes and other related community based information for children and families.

MCHB funding to the Medical Home Leadership Network ended in March 2004. The final evaluation of the project will identify strategies in approaching physicians in order to increase the number of medical homes statewide. Additionally, through the analyses of the 2002 CAHPS survey, the percent of medical homes for health plans participating in the survey will be calculated.

The WISE Grant partnered with MHLN's Annual Conference in November, 2003, sponsoring family attendance at the conference and providing a second day for families to develop leadership skills to promote medical homes in their communities.

WISE Grant pilot sites include members of local Medical Home Teams on their local steering committees to incorporate medical homes into community systems of care. (Fig. 4a, NPM 3, Act. 2).

Support continues for regional Maxillofacial Review Teams and for CSHCN Coordinators to have exposure to new products and resources to encourage physicians in their communities to embrace the medical home concept.

The CSHCN Coordinators in 16 local health jurisdictions participate as members of their Medical Home Team. Many use MCHBG funds to support that participation.

### c. Plan for the Coming Year

The CSHCN Program will contract with CHRMC to create a data publication that provides a comprehensive picture of children with special health care needs at the community level and in Washington State, using National CSHCN Survey, county profiles, and results of other assessment activities. (Fig 4a, NPM 3, Act. 1)

Support of the current and ongoing activities of MHLN will continue with funding from our program, staff involvement and leadership. The CSHCN Program will specifically contract with the MHLN to conduct a needs assessment of the state's Medical Home Physician Team members to identify targeted education strategies for promoting medical homes. MHLN will plan and host a fall 2004 meeting with physicians and other providers to move the education plan forward. Additionally, MHLN will analyze data from the 2004 key informant interviews of parents who attended the Center for Human Development and Disability (CHDD) tertiary clinic to provide recommendations for other clinics to pilot medical home strategies.

Methods will be determined to better integrate the MHLN with the CSHCN Nutrition Network and network of community-based feeding teams.

The WISE Grant will give attention to current work defining the role of the care coordinator and the importance of seamless care coordination. Additional pilot sites, which will incorporate Medical Home Teams and the role of a medical home in coordinated care for a child and family will be encouraged and developed. (Fig 4a, NPM 3, Act. 2)

Support will continue for Maxillofacial Review Teams. Additional opportunities for training, technical assistance, resources, and materials will be made available to local CSHCN Coordinators.

Contracts with the LHJs will be reviewed for activities related to medical home teams, and information shared as appropriate. (Fig. 4a, NPM 3, Act. 3)

*Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

### a. Last Year's Accomplishments

The CSHCN Program contracted with the Center for Children with Special Needs (CCSN) at Children's Hospital and Regional Medical Center (CHRMC) to jointly develop a plan to provide ongoing analysis of available data on children with special needs, including the National CSHCN Survey. Baseline percent calculated during 2003 was used to determine the target percent for improvement. (Fig. 4a, NPM 4, Act. 1)

The CSHCN Program uses Child Health Intake Form (CHIF), the statewide database for children served by Title V, and the Health Service Authorization (HSA), a statewide database of Title V expenditures for direct services, to identify children who have insurance. In March 2003, the CSHCN program's contractor, Strategic Services, conducted CHIF trainings for local CSHCN Coordinators to improve the quality and completeness of data, including better information about the source of insurance for each child served.

Work continued with CHRMC and pilot sites to collect nutrition assessment data on children with special health care needs and manipulate a data system to generate results. (Fig. 4a, NPM 4, Act. 2)

Interagency collaborations continued in a variety of ways for discussion of health care coverage. The quarterly Communication Network meeting brings together CSHCN staff, representatives from local health jurisdictions, managed care plans, Medical Assistance Administration (MAA), and CSHCN contractors; and the cross-agency Medicaid Integration Team (MIT) links state staff from the CSHCN Program, MAA and the Health Care Authority's Basic Health Plan (for low income individuals). (Fig. 4a, NPM 4, Act. 3)

CSHCN continued to earmark diagnostic and treatment funding for medically necessary services not covered by any other source. In the past, funding requests were minimal and used mainly for nutrition supplements, hearing aid batteries, and adaptive equipment since financial eligibility is the same as required for Medicaid.

The CSHCN Program collected anecdotal data from local health jurisdictions and managed care plans and tracked the use of diagnostic and treatment funds to measure the level of public and private resources, including insurance coverage for undocumented children with special health care needs whose state-funded Medicaid ended in October 2002. The CSHCN diagnostic and treatment fund saw an increase in expenditures. (Fig. 4a, NPM 4, Act. 4)

## b. Current Activities

The CSHCN "Road Show" developed jointly through the contact with CHRMC, provided initial results of the National CSHCN Survey. The Road Show was presented statewide to groups of local health agencies, parent organizations, health plans and others. These groups indicated a need to know more about children in Medicaid managed care and children with fee-for-service Medicaid coupons, especially in regard to access to specialty care. Parental employment status among responders to the survey was requested, since this could be indicative of gaps in insurance coverage for children. Information about sources of payment for respite care as part of health coverage was also of interest. (Fig. 4a, NPM 4, Act. 1)

Criteria were agreed upon, finalized, and incorporated into the Strategic Services' developed software for the CHIF database. Beginning January 2004, all local health staff were utilizing more uniform standards to increase completeness and comparability of the data, including source of insurance for health care.

Work continued with CHRMC and pilot sites to collect nutrition assessment data on children with special health care needs and manipulate a data system to generate results. A report template based on nutrition data collected in Spokane from 1996-2003 is under development. A cost analysis report on the benefits of having a reimbursement system in place for nutrition services and nutrition supplements for children with special health care needs was completed. A limited number of hard copies are being distributed; an electronic version of the report was posted on the MCH/CSHCN website. (Fig. 4a, NPM 4, Act. 2)

The CSHCN Program's quarterly Communication Network meeting, which includes case managers from managed care plans who cover both Medicaid and private insurance customers, will continue as a place to share concerns and discuss solutions. Monthly meetings with representatives of Medicaid managed care and fee-for-service, and from Basic Health Plan continue to probe issues about health coverage.

The CSHCN Program continues to develop trainings to assist families and care coordinators in understanding how to navigate health services. A presentation, "Paying the Bills", was made by the CSHCN Nurse Consultant and Family Consultant at the April 2004 Early Childhood Conference. (Fig. 4a, NPM 4, Act. 3)

The CSHCN Program reviewed information from a survey documenting requests for services

from the local public health agencies by non-citizen children; then developed strategies to pursue providing medically necessary services. The information was aggregated and is being shared with appropriate partners. Beginning July 1, 2004, Medical Assistance Administration, at the direction of the state Legislature, will charge premiums for children's Medicaid coverage based on the family's income, child's age and family size. (Fig. 4a, NPM 4, Act. 4)

### c. Plan for the Coming Year

Depending upon the outcomes of the MCH 5 Year Needs Assessment, additional insurance data from the National CSHCN Survey could be analyzed and used for planning priorities. Continued monitoring of the anticipated release of the 2005 National CSHCN Survey will continue and use of insurance data will be incorporated into the state level publication to be published in 2005.

Insurance coverage will be specifically addressed in the data publication through the CCSN contract. Data reported will include that from the CSHCN National Survey, county profiles, and results of other assessment activities. (Fig. 4a, NPM 4, Act. 1)

The CHIF database will have ongoing quality checks as the current criteria are implemented locally for data entry. Through the contract with the CSHCN Program, Strategic Services will continue to provide consultation and training to local partners in order to improve data quality for all data items, including insurance source for children in the system.

Plans for the dissemination of the results of nutrition assessment data for children with special health care needs will be determined. (Fig. 4a, NPM 4, Act. 2)

Interagency collaboration through various forums such as the Communication Network and MIT, and interaction with managed care plans will continue. Ways to connect with more commercial insurance plans will be explored. The CSHCN Program will work with MAA partners to stay apprised of the numbers of children leaving Medicaid coverage; and will actively elicit anecdotal and other information about children whose families cannot afford premiums.

The CSHCN Program is reviewing and updating parent and provider resource information on "Paying the Bills". (Fig. 4a, NPM 4, Act. 3)

The CSHCN Program will continue to monitor the use of Diagnostic and Treatment funds for undocumented children with special health care needs, and will share information with partners as appropriate. Additional attention will be focused on requests for financial support for medical care and supplies made to CSHCN Coordinators for children who may have lost their Medicaid coverage because the family was unable to pay the required premiums. (Fig. 4a, NPM 4, Act. 4)

*Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

### a. Last Year's Accomplishments

Through the CHRMC contract, a baseline percent for this performance measure was calculated and target percents for improvement were determined. Activities and strategies were identified to reach these targets. Washington state findings were presented at the Washington Joint Conference on Health in October 2002 and at the national AMCHP Conference in March 2003. (Fig. 4a, NPM 5, Act. 1)

Work through the WISE Grant pilot sites tested care coordination models and documented the barriers and the features of a successful care coordination system. Families have been an active part of policy development through their participation on the Care Coordination subcommittee and participation in a Family Advisory Network (FAN) conference and focus groups. (Fig. 4a, NPM 5, Act. 2)

In 2003, the CSHCN Communication Network presented forums to expand knowledge of all our partners about services available to children and families. Topics of note were mental health services, undocumented children's health issues and health services and programs in schools. At the community level, the Okanogan Health District CSHCN Coordinator brought together a group of community service providers and parent organizations to participate in a community forum to increase awareness of services for children with special needs. CSHCN staff were invited to attend and tell the story of Title V and the CSHCN Program in Washington State.

In 2003, workshops were again held to support the CSHCN Nutrition Network and community-based feeding teams through a contract with the Center on Human Development and Disability at the University of Washington (UW). CSHCN nutrition training topics were integrated into continuing education for WIC nutritionists, UW nutrition graduate students, and pediatric dietitians.

The CSHCN Program contracted with CHRMC to develop web-based resource lists for families of children with special health care needs. All CSHCN Coordinators were invited to submit resource information specific to their county.

To further family knowledge, "The Big Picture" of CSHCN health systems services and cross agency partners was developed and presented to Family Advisory Network and Washington Family to Family Network members in late 2003. (Fig. 4a, NPM 5, Act. 3)

CSHCN Program continued to support the infrastructure of 14 neurodevelopmental centers. These centers have increased their capacity to provide community-based services; reduce waiting lists for families with young children needing early intervention services; and expand the array of available services to include new services such as aquatic therapy, feeding groups, sibling support, integrated childcare, respite care training, and community playgrounds. (Fig. 4a, NPM 5, Act. 4)

## b. Current Activities

CSHCN Program contracted with CHRMC to conduct sub-analyses of National CSHCN Survey to further address this performance measure. The contract included development of the CSHCN "Road Show" which was shared with local health, parent organizations, health plans and other stakeholders. Discussions at the presentations revealed that data from other agencies and programs was of great interest in helping determine how community service systems were working for children and families. Some of the data of interest are from Birth to 3, ECEAP, Head Start, schools, Work First and Native American Tribes. (Fig. 4a, NPM 5, Act. 1)

WISE Grant system assessment is identifying structures at state and local levels that may prevent easy access to the community-based service system. Washington Administrative Code (WAC), policies, procedures, traditional thinking, and other barriers are being identified. Recommendations from the assessment findings are being formulated for possible policy changes. (Fig. 4a, NPM 5, Act. 2)

The CSHCN Communication Network continues to be the conduit for questions from local CSHCN Coordinators who encounter systems difficulties as they work with children and families. The CSHCN Program staff work with other state agency staff to research and find

answers to the questions raised.

The CSHCN Program continues to contract with CHRMC to collect resource information for families of children with special health care needs for web posting. CSHCN Coordinators are encouraged to provide the information from their county to be included on this website.

Through an information-gathering process with the WorkFirst Program, Children with Special Needs Initiative at DSHS, the CSHCN Program has started to identify barriers and gaps in services that inhibit parents of children with special health care needs from participating in the WorkFirst Program, the Washington State assistance program that helps parents meet family care needs that are barriers to being employed. (Fig. 4a, NPM 5, Act. 3)

The CSHCN Program continues to support the infrastructure of 14 neurodevelopmental centers.

Additional support for community agency collaboration is addressed in the contract supporting the ASK Line at HMHB. The CSHCN Program identified new data elements for the updated ASK Line data collection system which will provide us with better data about the needs of the population we are serving. County Resource Lists were developed and ASK line web linkages were enhanced to provide more community level information for families and providers. (Fig. 4a, NPM 5, Act. 4)

CSHCN Coordinators in most locations are active participants on their Community Interagency Coordinating Councils. Specific local Coordinator activities include: Assisting families with telemedicine conferences for specialized services; developing a community timeline for local services; working with community providers and the Medicaid managed care contractor to assess services and improve access.

### c. Plan for the Coming Year

Work in the contract with CHRMC will include creating a data publication that provides a comprehensive picture of children with special health care needs both locally and statewide, using the National CSHCN Survey, county profiles, and results of other assessment activities. Depending upon the outcomes of the MCH 5 Year Needs Assessment, additional data from the National CSHCN Survey could be analyzed and used for planning priorities. (Fig. 4a, NPM 5, Act. 1)

WISE Grant staff and the Steering Committee will prepare a briefing document with recommendations for statewide system integration. A strategy will be developed for sharing within DOH and other agencies. A Social Marketing retreat for WISE Grant stakeholders will provide greater understanding of social marketing concepts and process. (Fig. 4a, NPM 5, Act. 2)

Methods will be determined to better integrate the Medical Home Leadership Network with the CSHCN Nutrition Network and network of community-based feeding teams to improve access to array of coordinated services for families with children with special health care needs.

The CSHCN Program will continue to maintain the network of CSHCN Coordinators and interagency collaborations and to provide forums that include families as partners.

The CSHCN Program will continue to collaborate with the WorkFirst Program at DSHS to identify gaps in services for families of children with special health care needs. (Fig. 4a, NPM 5, Act. 3)

The CSHCN Program will continue to support the infrastructure of 14 neurodevelopmental

centers, the ASK Line and other contractors to continue to obtain pertinent information about the children and families involved with them. (Fig. 4a, NPM 5, Act. 4)

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

#### a. Last Year's Accomplishments

The CSHCN Program worked via a contract with the Adolescent Health Transition Project (AHTP) at the UW. Through this contract, and in collaboration with a number of advisory board members including Family Educator Partnership Program (FEPP), CSHCN developed "Working Together for Successful Transition: Washington State Adolescent Health Transition Resource Notebook".

The widely used "Transition Timelines for Developmental Disabilities/Delays" was updated to include birth to three information and versions in Spanish, Vietnamese, Russian and Chinese.

An analysis of the teen Health History Summary neared completion. (Fig. 4a, NPM 6, Act. 1)

Partnerships with the OMCH, CAH program, OSPI, FEPP, Division of Development Disability, and Division of Vocational Rehabilitation were continued and enhanced through working collaboratively on the Transition Resource Notebook.

Partnerships with CAH Program and other MCH programs were increased. CSHCN Program staff collaborated on the Adolescent Fact Sheets produced through the CAH Program by helping create a new fact sheet targeted at adolescents with special health care needs. This new fact sheet drew heavily on the Transition Timeline developed by the AHTP. (Fig. 4a, NPM 6, Act. 2)

#### b. Current Activities

The AHTP Health History Summary findings showed that youth who participated in the health history summaries, along with their families, were more likely to take active roles in their own health care. The findings were submitted to Exceptional Parent for possible publication in the journal.

The Adolescent Health Transition Resource Notebook was evaluated by a number of readers, including parents from diverse ethnic cultures. Feedback was incorporated into the current version and plans made to expand the notebook to include more family stories from a variety of cultures. Artwork by youth with special needs was commissioned as a cover and chapter dividers. The notebook has been widely disseminated and in-services conducted. (Fig. 4a, NPM 6, Act. 1)

The Adolescent Health Transition Project is collaborating more closely with Medical Home Leadership Network and exploring the potential of adult medical homes for adolescents and youth. (Fig. 4a, NPM 6, Act. 2)

The CSHCN "Road Show", developed from the data analysis done through the contract with CHRMC, also highlighted information in the survey regarding adolescents, even though this was very limited. The discussions with stakeholders at these presentations provided input about other sources of data and other questions regarding adolescents' needs. (Fig 4a, NPM 6, Act. 3)

### c. Plan for the Coming Year

The Adolescent Health Transition Resource Notebook will be updated to include a section on culturally diverse transition stories, sexuality, and HIPAA regulations/privacy issues. In-services on how to use the notebook will be provided by the Adolescent Health Transition Project staff and the Family Educator Partnership Project, focusing on schools and school nurses, as well as other audiences.

A new health insurance document will be developed to assist adolescents with special health care needs transitioning into adulthood.

AHTP staff will develop a work plan based on research into the use of youth advisory boards in planning and policy for adolescent services. Using the work plan, a pilot youth advisory board will be designed and implemented. Youth will be recruited, mentored, and involved in addressing issues of importance to adolescents with special needs in this state. (Fig. 4a, NPM 6, Act. 1)

In response to the Medical Home State Plan (MSHP) goals of increasing awareness and existence of medical homes for children and adolescents with special needs, the AHTP will formulate a five-year plan to improve adolescent health transition in Washington state. AHTP will collaborate with the CSHCN Program, Child and Adolescent Program, and other partners of the MSHP, including the Washington Chapter AAP representative, the Center for Children with Special Needs at CHRMC, family physician, Title V, etc. (Fig. 4a, NPM 6, Act. 2)

The CSHCN Program's contract with CHRMC will begin to develop care plans for adolescents. This will be done with input from focus groups of adolescents, parents and providers. These plans will provide guidance to adolescents and their families to assist in planning for transition to adult medical care and other health issues of adults. Information from the Health History Summary evaluation will be used to guide the information included in the care plans. (Fig 4a, NPM 6, Act. 3)

*Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

### a. Last Year's Accomplishments

The estimated vaccination coverage for children in Washington State aged 19-35 months for 4:3:1:3:3 according to National Immunization Survey data for Q3 2002-Q2 2003 was 72.8 + 4.8.

The Immunization Program contracted with all 35 LHJs to complete immunization AFIX (assessment, feedback, incentive, and exchange) visits to enrolled private immunization provider sites. In addition, the state hosted three conference call trainings for LHJs. The trainings covered the 2003 AFIX requirements. State Immunization staff provided AFIX technical assistance including phone consultation, materials, forms development, and site visits as needed. (Fig. 4a, NPM 7, Act. 1)

The Immunization Program, in partnership with the Asian Pacific Islander (API) task force, implemented adolescent hepatitis B screening, education, and vaccination activities in two high schools with high API populations. A prenatal care provider survey was completed in March 2003, focusing on current practices in disease prevention including perinatal hepatitis B practices. 100 percent of OB providers (690) reported screening every pregnant woman for hepatitis B as part of the routine blood work. 81 percent of the providers responded that they report all HBsAg positive women. The Immunization Program continues to distribute the Perinatal Hepatitis B guidelines to hospitals, providers, and LHJs. (Fig. 4a, NPM 7, Act. 2)

The IP continued to fund the statewide WIC/Immunization Program Planning Workgroup. This group completed the second phase of a three to five year strategic plan for linkage activities to increase immunization rates by identifying and defining goals and activities. A WIC/Immunization Program Record Round-Up Project was implemented May 1, 2003 at twenty-one WIC agencies in fifteen counties. In 2003, OMCH implemented new immunization requirements for school entry to include Hepatitis B up to sixth grade level and a second MMR up to third grade. (Fig. 4a, NPM 7, Act. 3)

During 2003, the IP contracted with two Washington tribes. Both tribes have enrolled in the CHILDP Profile Immunization Registry and are entering immunization information for all their tribal children. Coverage assessments were also planned as well as health fairs and other clinical immunization efforts to increase coverage rates. (Fig. 4a, NPM 7, Act. 5)

As of March 31, 2003, the CHILDP Profile Immunization Registry and Health Promotion System sent 354,736 well-child checkup and immunization reminders to parents of children 0 to 6 years of age, as well as other parenting information (Fig. 4a, NPM 7, Act. 6). Additionally, the percentage of children 19 to 35 months of age with complete immunizations in the system increased to 16 percent. Implementation of the provider recruitment plan resulted in 19 percent of providers agreeing to participate in the registry, up from 10 percent in December 2002. (Fig. 4a, NPM 7, Act. 7)

#### b. Current Activities

The Immunization Program (IP) will continue to contract with the LHJs to complete AFIX site visits on at least 20 percent of all enrolled private immunization providers in Washington state. Training for new staff and technical assistance will be provided. Data regarding provider immunization coverage rate changes will be shared with LHJs. (Fig. 4a, NPM 7, Act. 1)

The IP will continue to promote the reporting of perinatal hepatitis B among providers in order to increase the number of women who are HBsAg+ who are reported for follow-up. Through education, outreach, and strengthening of the perinatal hepatitis B program, increase the number of infants born to women who are HBsAg+ completing the three dose Hepatitis Series by 12 months of age to 80 percent. An outreach and education project directed at prenatal care providers was conducted in October 2003. The Immunization Program is working with Maternal Infant Health program to reinforce screening of pregnant women and reporting of HBsAg+ women (with an emphasis on the reporting, as screening rates are 100 percent). (Fig. 4a, NPM 7, Act. 2)

The WIC/Immunization Program Planning Workgroup conducted an evaluation of the 2003 Record Round-Up Project and enthusiastically supported conducting a similar activity from May to December 2004. Agencies are currently being selected for participation. Abstracts on the WIC/Immunization Record Round-up Project and the foundation culture work for the statewide WIC/Immunization Program Planning Workgroups have been selected for presentation at the National Immunization Conference in May, 2004. In September 2004, OMCH is implementing new immunization requirements for school entry to include Hepatitis B up to seventh grade level and a second MMR up to fourth grade level. (Fig. 4a, NPM 7, Act. 3)

CHILDP Profile and the WIC program are solidifying plans to develop a linkage between the WIC Client Information Management System (CIMS) and the CHILDP Profile Immunization Registry. This linkage will help to facilitate the USDA requirement for WIC to screen DTaPs for children 0 to 2 years of age. As of January 31, 2004, parents of 390,107 children 0 to 6 years of age are being sent reminders of the need for well-child checkups and immunizations, including other important parenting information (Fig. 4a, NPM 7, Act. 6). In 2004, we anticipate full statewide expansion of the CHILDP Profile health promotion system. By June 30, 2004, 90 percent of

parents of children 0 to 6 years of age will be sent reminders of the need for well-child checkups and immunizations (Fig. 4a, NPM 7, Act. 6). Implementation of the provider recruitment plan resulted in an additional 383 (34 percent) of providers agreeing to participate in the registry, up from 19 percent in 2003. (Fig. 4a, NPM 7, Act. 7)

All local public health agencies have contracts with the Immunization program, which resides in OMCH. Four rural agencies assist schools with Immunization record maintenance.

### c. Plan for the Coming Year

The IP will continue to contract with the LHJs to complete AFIX site visits on at least 20 percent of all enrolled private immunization providers in Washington state. Training for new staff and technical assistance will be provided. Data regarding provider immunization cover rate changes will be shared with LHJs. (Fig. 4a, NPM 7, Act. 1)

The IP will conduct high school education, screening, and vaccination for Hepatitis B in 1-2 high schools with API population of 25 percent or more. Immunization best practices for juvenile correction centers will be researched and developed by the end of year 2004. A pilot for best practices will be developed and implemented in 2005. The Perinatal Hepatitis B Prevention Program will continue to be supported.

CHILD Profile and the WIC program continue to work towards linkage of the Client Information Management System (CIMS) and the CHILD Profile Immunization Registry. This linkage will help to facilitate the USDA requirement for WIC to screen DTaPs for children 0 to 2 years of age. Pilot projects are expected to be selected by mid-2005. Additionally, OMCH will be implementing new immunization requirements for school entry to include Hepatitis B up to the eighth grade level and a second MMR up to the fifth grade.

The IP plans to continue funding for interested Washington tribes to participate in projects that include assessment of immunization coverage of some of their members as well as activities to enhance vaccination coverage rates of native populations within the state. (Fig. 4a, NPM 7, Act. 5)

In 2005, CHILD Profile Health Promotion will continue working towards increasing the number of parents of children aged 0 - 6 years of age who are sent reminders of the need for well-child checkups and immunizations. (Fig. 4a, NPM 7, Act. 6)

Continued implementation of the CHILD Profile provider recruitment plan should result in an additional 700 (about 77 percent) private provider sites participating. Most public sites are already participating. The statewide expansion goal for the Immunization Registry is to have 95 percent of providers participating by 2006. (Fig. 4a, NPM 7, Act. 7)

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

### a. Last Year's Accomplishments

OMCH continued to implement the Title V Abstinence Education Program in Washington State. Only four community-based projects were successfully concluded at the end of the fiscal year. The evaluation of these sites, along with the Lessons Learned report from UW/Washington Institute, dictated the shift from community-based interventions to a media-based approach. Additionally, research from other states also recommended applying a combination of media campaigns and community-based interventions in targeting youth and parents. (Fig. 4a, NPM 8, Act. 1)

By utilizing a youth development approach, the Teen Pregnancy Prevention Program completed funding 14 sites across the state. These sites provided family planning services and/or community-based interventions to youth at varying levels of risk. The sites also participated in an evaluation conducted by UW/Washington Institute. (Fig. 4a, NPM 8, Act. 1)

Strategic planning and development was also accomplished in order to improve program efficiency, meet current and future needs of target population, and to create a long-term vision for Washington State in terms of teen pregnancy prevention. (Fig. 4a, NPM 8, Act. 1)

## b. Current Activities

**Abstinence Education:** Funding for community-based programs was discontinued this year as a result of weak evaluation outcomes. OMCH is applying a two-pronged media-based approach towards abstinence education: (1) a statewide public awareness campaign and (2) a media literacy curriculum. By gaining insight from other states and by identifying best practices around abstinence education funding, OMCH is laying the foundation for a statewide public awareness campaign addressing abstinence and benefits of delaying sexual activity. Currently, focus groups are being conducted with parents of young teens and youth ages 10 through 14 in various locations throughout the state. The purpose of these focus groups is to gather reactions on existing media messages in addition to collecting data on knowledge, attitudes, and beliefs around abstinence, sexual activity, and positive youth development. The final results from the focus groups will be available by October 31, 2004 and will inform the development of the campaign, anticipated to begin in 2005. The campaign may include public service announcements, television ads, radio ads, and/or other forms of media messages.

Simultaneously, a media literacy curriculum is also being developed that will enable middle-school aged youth to deconstruct media messages related to sexual activity. The curriculum will be piloted in 5 sites throughout Washington and will be taught by youth leaders in those sites. The pilot sites will undergo thorough evaluation in order to determine efficacy and future implementation. (Fig. 4a, NPM 8, Act. 7)

**Youth Development Program:** OMCH recently put forward a Request for Proposal that seeks to decrease the incidence of teen pregnancy in selected communities. The aim is to reduce teen pregnancy among youth who are at higher risk through community-based teen pregnancy prevention projects. A secondary goal is to eliminate health disparities in communities with high rates of teen pregnancy. Due to limited funding, only 3-5 selected sites will implement community-based interventions with a family planning component. The projected start date for these projects is July 1, 2004 and they will be funded for an initial period of 12 months.

Concurrent evaluation and monitoring of these sites will determine effectiveness. (Fig. 4a, NPM 8, Act. 3)

**Local efforts to reduce teenage birth rates include:** Participating on local Teen Pregnancy Prevention Task Forces; developing media stories and links to publicize the situations in their communities; conducting an assessment of teen pregnancy from 1980 -- 2001; providing family planning services to improve access in a small community. (Fig. 4a, NPM 8, Act. 6)

## c. Plan for the Coming Year

**Abstinence Education:** Contingent on future funding of the Abstinence Education program, OMCH hopes to realize the statewide public awareness campaign in 2005. A media firm will be chosen to strategize, develop, and implement the campaign following a competitive selection process. The duration and type of the campaign will depend largely on funding and focus group results. Similarly, the media literacy curriculum will be extended to other communities subject to successful evaluation results from pilot sites. Evaluation and monitoring of new sites will be continued to ascertain effectiveness. (Fig. 4a, NPM 8, Act. 7)

Youth Development Program: Selected sites will continue addressing teen pregnancy prevention by implementing community-based interventions with a family planning component. Sites may be awarded additional funding only after successful completion of the initial 12-month project period. Evaluation and monitoring will be sustained on a yearly basis. (Fig. 4a, NPM 8, Act. 3)

*Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

#### a. Last Year's Accomplishments

There are a small number of LHJs with qualified staffs that provide sealants to underserved children in schools or clinics. Most LHJs do not have adequate funding or licensed staff to provide this service directly and instead focus on referring clients to OH services that already exist within their communities, including Title XIX funded services.

Funding for Oral Health (OH) activities was included in thirty-one of the thirty-four LHJ Consolidated Contracts in 2003. Three of the smaller jurisdictions were unable to develop a plan for OH funds. LHJs continued OH planning and infrastructure development activities as a basis for local OH programs and services. Scheduled LHJ trainings included a November 2003 multi-day retreat and a May 2003 single-day event. Additional technical assistance to individual LHJs was provided upon request, by OMCH and through special training resources such as the Yakima Valley Farmworkers Clinic. (Fig. 4a, NPM 9, Act. 3)

In consultation with OMCH Assessment section, the Oral Health program staff initiated planning and preparations for the statewide Smile Survey to be conducted in early 2005. The Smile survey includes examination of children's teeth to determine the number of underserved children who have sealants on at least one permanent molar tooth. Some sealants are provided as a part of this survey. (Fig. 4a, NPM 9, Act. 1)

OMCH and HSQA began developing a plan to review and report on the implementation of the 2003 SSB 6020 law that created a school-based sealant and varnish program. (Fig. 4a, NPM 9, Act. 4)

OMCH applied for and was awarded a federal HRSA State Oral Health Collaborative Systems (SOHCS) grant in September 2003 to implement recommendations from the State Oral Health Summit of Oct. 2002. OMCH will partner with the private Washington Dental Services Foundation (WDSF) to train medical practitioners to provide dental screening and care to underserved children.

Oral Health information was presented at the annual Joint Conference on Health in October 2002, with participation from the WA State OH Coalition and LHJs. During the fall, the OH program collaborated with the DOH Office of Drinking Water (ODW) in a statewide series of regional training forums to offer information about water fluoridation. Increased communication and linkages between local water system and personal health personnel occurred.

#### b. Current Activities

Additional training and technical assistance support is being provided to LHJs as they refine local OH programs to benefit MCH populations. LHJs are actively involved in local sealant programs. LHJ training and professional development events are scheduled for May and October 2004. Oral Health plans for the next Consolidated Contract cycle 2005-2006 are due in fall 2004. (Fig. 4a, NPM 9, Act. 3)

Smile Survey planning is proceeding, involving primarily OMCH Assessment staff, OH Staff, the Office of the Superintendent of Public Instruction, and a consultant Oral Epidemiologist. Survey screeners are being trained and calibrated, and LHJs are being trained to use the Epi-Info oral health software for data recording. (Fig. 4a, NPM 9, Act. 1)

OMCH is contracting with the University of Washington School of Dentistry for expert assistance in developing the oral health component of the state adolescent health services plan. UW is also facilitating an interagency effort among DOH, DSHS, and OSPI to identify early intervention opportunities for children's oral health.

OMCH continues its support for and involvement with the Washington State Oral Health Coalition, and other activities that promote oral health for low-income children. Further collaboration is occurring with DSHS MAA on the Medicaid sealant services and ABCD programs; ODW and WA State Dental Association (WSDA) on water fluoridation issues; and the WA Dental Services Foundation on developing dental training for pediatricians and other medical personnel.

Oral Health is recognized as important to the health the whole individual. Local agencies used MCHBG funds to support oral health in the following ways: Provided additional support to their area's ABCD program, participated on local dental coalitions; developed a dental access plan as part of the Community Health Center federal application; developed dental care for 0 -- 18 year olds through a grassroots community organization; and provided trainings to local primary care physicians that resulted in making oral health a part of each well child visit.

#### c. Plan for the Coming Year

Smile Survey data will be collected early in 2005 in elementary schools and child care/child development centers. One element of the survey will be the sealants on molars in third graders. The Smile Survey data will be analyzed and a report published by the end of the 2005. Data from Medicaid, ABCD programs, and other sources will be compiled and analyzed to gain a better understanding of access issues in the state. (Fig. 4a, NPM 9, Act. 1)

Existing community and organizational partnerships will be maintained and strengthened, and new ones created, so that oral health programs are extended to the underserved. Concentrated efforts will be devoted to optimize and sustain the working partnerships with the UW School of Dentistry, the Washington Dental Services Foundation, and the WA State Dental Association. When available, additional HRSA SOHCS funds will be sought to promote OH infrastructure development.

After review and approval of the local plans, oral health funding will be included in all MCH 2005-2006 Consolidated Contracts to all LHJs. Training will be provided to LHJs. School-based sealant activities and services provided under SSB 6020 will be documented in a report to the Legislature by December 2005. (Fig. 4a, NPM 9, Act. 3)

*Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

#### a. Last Year's Accomplishments

OMCH's Child Death Review (CDR) Program addressed prevention of unexpected deaths to children ages 0 to 18 including motor vehicle crash deaths of children aged 14 years and younger. This activity is essential for assessment purposes, targets children in Washington State, and is an infrastructure service. Thirty teams convened by local public health reviewed deaths to children under age 14. Prevention issues CDR identified included enforcement of the

primary seat belt law for adults as well as children, additional legal penalties for adults who drive drunk with children, and booster seat. (Fig 4a, NPM 10, Act. 3, 4)

In 2003, CHILD Profile continued to send car/booster seat, air bag and safety information to parents of children 0 to 6 years of age as they did in 2002. CHILD Profile also partnered with the Injury Prevention Program to develop an English/Spanish insert that is mailed in the introduction letter titled, "Choosing a Safe Car Seat." (Fig. 4a, NPM 10, Act. 1)

Several LHJs participated in Safe Kids Coalitions, which targeted car seat safety inspections and/or free car seats. (Fig. 4a, NPM 10, Act. 6)

## b. Current Activities

Due to Washington State's financial crisis, state funding that supports the Child Death Review (CDR) program was eliminated from the biennium budget. Currently 19 of the 30 original LHJs have indicated a commitment to continue the work. (Fig. 4a, NPM 10, Act. 3)

OMCH is continuing to maintain the CDR state database and will continue to provide technical assistance for local teams. A new web-based reporting system is available for local teams. The Washington State Child Death Review State Committee published a report in March 2003 which contained recommendations based on Child Death Review data to prevent motor vehicle crash deaths and injuries. Recommendations included enforcement and education about Graduated Driver Licensing, enforcement of the Primary Seatbelt Law, and enhancement of DUI Laws. (Fig. 4a, NPM 10, Act. 4)

OMCH is working collaboratively with the Injury Prevention program at DOH to produce a report entitled "Childhood Injury in Washington State", which will include information on Motor Vehicle Crashes and recommendations on preventing deaths due to MVC. (Fig. 4a, NPM 10, Act. 6)

Twelve contractors used MCHBG funds to focus on car seat safety, including inspections and providing free or reduced-cost car seats. Of specific interest were these additional activities: Collaboration with the County Sheriff's office, private insurance, and the Hispanic community to provide child passenger safety and education activities; and development of a pregnancy tracking system that incorporated tracking the use of car seats for infants.

## c. Plan for the Coming Year

OMCH will work with the local CDR teams who are continuing to function. The state database and reporting system will continue to be supported. Technical assistance will continue to be offered to local teams. (Fig. 4a, NPM 10, Act. 3)

OMCH will publish collaboratively with the Injury Prevention program at DOH a report entitled "Childhood Injury in Washington State", which will include information on Motor Vehicle Crashes and recommendations on preventing deaths due to MVC. (Fig. 4a, NPM 10, Act. 6)

In 2005, CHILD Profile will continue sending car/booster seat, air bags and safety information to parents of children 0 -- 6 years of age. Information will be refined as statewide data changes. (Fig. 4a, NPM 10, Act. 1)

OMCH will participate in an advisory committee to Harborview Hospital to support a CDC grant focusing on a demonstration project with 4 local CDR teams to link regional EMS injury prevention coordinators to local teams. Additionally, this project will provide teams with a data analysis and decision-making tool to allow them to generate prevention recommendations. (Fig. 4a, NPM 10, Act. 5)

OMCH staff will continue to collaborate with the DOH Injury Prevention Program on activities that are common priorities for both programs. (Fig. 4a, NPM 10, Act. 6)

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

**a. Last Year's Accomplishments**

Maternity Support Services (MSS) agencies provided breastfeeding support and teaching to low income women on Medicaid. In 2003, 200 MSS providers were trained in breastfeeding support and teaching techniques. (Fig. 4a, NPM 11, Act. 1, 2, & 3)

Several LHJs provided a variety of breastfeeding promotion activities including: education, outreach, one-to-one support to mothers, pump loans, coalition building, and assessment.

**b. Current Activities**

At one First Steps ABC training, 85 new MSS providers received training in breastfeeding support and teaching techniques. MSS local agency staffs provide breastfeeding promotion as part of their health education to about 70 percent of Washington's Medicaid eligible women giving birth per year, which is about 24,000 women. (Fig. 4a, NPM 11, Act. 1 & 2)

The "Perinatal Level of Care Guidelines" (LOC) document, completed in 2001, recommends lactation support at all hospitals with delivery services. The LOC guidelines are used as a reference by the Certificate of Need program for hospitals inquiring about recommended services including lactation services. The LOC are available on-line, linked to the Washington State DOH website, for use and dissemination to all interested parties. (Fig. 4a, NPM 11, Act. 4)

The revision process for the LOC will begin in 2004. It is anticipated that due to growing evidence of the benefits of breastfeeding for mother and baby, the LOC Guidelines revision will continue to recommend lactation support for all hospitals with delivery services. (Fig. 4a, NPM 11, Act. 4)

PRAMS data continues to be collected and analyzed on breastfeeding initiation rates and duration at one month and two months postpartum (Fig. 4a, NPM 11, Act. 5). Updates to 2001 and 2002 data are anticipated this year.

A number of counties provided a variety of activities related to increasing the percentage of mothers who breast feed their infants at hospital discharge including education, outreach, one-on-one support to breastfeeding mothers, pump loans, coalition building in the community, and assessment. Other activities include completing a pilot study of moms who breastfed beyond 2 months postpartum, providing lactation consultation and speaking to childbirth classes about breast feeding, and providing women with loaner breast pumps to support their continuing desire to breastfeed their babies.

**c. Plan for the Coming Year**

The First Steps program expects to train a minimum of 170 new MSS staff in breastfeeding promotion and support. Training will emphasize motivational interviewing approach in client education. MSS providers across the state will continue to provide breastfeeding support and teach low-income pregnant and parenting women. In the Redesigned MSS program, breastfeeding promotion is one of the Basic Health Messages that Program staff are required

to provide each MSS client. (Fig. 4, NPM 11, Act. 1 & 2)

The revision process for the LOC will begin in 2004 and be completed in FFY 2005. It is anticipated that due to growing evidence of the benefits of breastfeeding for mother and baby, the LOC Guidelines revision will continue to recommend lactation support for all hospitals with delivery services. (Fig. 4a, NPM 11, Act. 4)

*Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.*

#### a. Last Year's Accomplishments

In 2003, the Early Hearing Loss Detection, Diagnosis, and Intervention (EHDDI) Program continued to pilot Phase I of the EHDDI Tracking and Surveillance System (Fig 4a, NPM 12, Act.1), and to work with 7 participating hospitals to ensure high initial screening rates, and decreased rescreen and referral rates. Phase I focuses on the collection of hearing screening data from hospitals. Contractors and EHDDI staff completed Phase II development; Phase II is a web-based system to allow audiologists to access their patients' Phase I data, as well as to enter results from diagnostic evaluations of these patients.

In early 2003, EHDDI Program staff gathered data showing that in 2002, approximately 62 percent of infants born in Washington were screened for hearing loss. (Fig 4a, NPM 12, Act. 2)

The EHDDI Program continued to contract with Children's Hospital and Regional Medical Center (CHRMC) to provide technical assistance to hospitals and develop educational materials. (Fig 4a, NPM 12, Act. 3)

DOH contracted with MSR Northwest to purchase hearing screening equipment for 19 birthing hospitals in the state that still lacked equipment and universal newborn hearing screening (UNHS) programs. (Fig 4a, NPM 12, Act. 6)

Medical Home Teams in three counties contracted with DOH to provide training and information about hearing screening and early intervention to providers in their areas, including Early/Tribal Head Start programs. (Fig 4a, NPM 12, Act 4)

In September 2003, DOH held a statewide EHDDI Early Intervention Provider Summit for various professional groups and parents to develop plans to 1) Ensure that children diagnosed with a hearing loss receive appropriate intervention services; 2) Ensure that families receive the support needed when a child is diagnosed with a hearing loss, and 3) Decrease the number of children lost to follow up. (Fig 4a, NPM 12, Act. 7)

The EHDDI Program worked with CHILD Profile to initiate development of an insert to educate parents about the importance of hearing screening and hearing screening milestones. CHILD Profile's 1 month and 3 month letters provided health promotion messages to encourage parents to speak with their health care provider if they have concerns about their child's hearing. Through a partnership with the Infant Toddler Early Intervention Program (ITEIP), CHILD Profile distributed information on hearing milestones in the 3 month, 6 month, 9 month, and 12 month mailings.

#### b. Current Activities

Phase II of the EHDDI Tracking and Surveillance System is currently available to pediatric audiologists from 15 clinics in Washington. EHDDI Program staff are adding additional hospitals to Phase I of the system, at a rate of approximately 5,000 births per month. Physician

focus groups were recently conducted to gain feedback about Phase I of the Tracking and Surveillance System. (Fig 4a, NPM 12, Act 1)

Data gathered recently by EHDDI Program staff show that in 2003, approximately 80 percent of infants born in Washington State received hearing screening, a significant increase from 2002. (Fig 4a, NPM 12, Act. 2)

DOH and CHRMC staff will continue to provide technical assistance to hospitals (Fig 4a, NPM 12, Act. 3), and MSR Northwest will purchase hearing screening equipment for the remaining hospitals that need it (Fig 4a, NPM 12, Act. 6). The EHDDI Program is also partnering with CHRMC, Washington Sensory Disabilities Services (WSDS), and Discoveries to develop an Early Intervention training program for early intervention providers, public health professionals, and parents who work with children deaf or heard of hearing. Initial trainings will be held in the summer, followed by ongoing video conferences for selected topics. (Fig 4a, NPM 12, Act. 7)

The EHDDI program and CHILD Profile are continuing to develop an insert to educate parents about the importance of hearing screening and hearing milestones. CHILD Profile's 1 month and 3 month letters provide health promotion messages to encourage parents to speak with their health care provider if they have concerns about their child's hearing. Through a partnership with the Infant Toddler Early Intervention Program (ITEIP), CHILD Profile distributes information on hearing milestones in the 3 month, 6 month, 9 month, and 12 month mailings.

#### c. Plan for the Coming Year

In 2005, EHDDI Program staff will add hospitals to Phase I of the Tracking and Surveillance System, at a rate of approximately 5,000 births per month. It is anticipated that all birthing hospitals will be on the system by March of 2005. Staff will revise and improve both Phase I and II in response to feedback from system users. (Fig 4a, NPM 12, Act. 1) Technical assistance, early intervention training, and parent and physician education will continue. (Fig 4a, NPM 12, Act. 3)

The EHDDI program and CHILD Profile will continue the process of creating an insert to educate parents about the importance of hearing screening and hearing milestones. CHILD Profile will continue providing health promotion messages in both the 1 month and 3 month letters to encourage parents to speak with their health care provider if they have concerns about their child's hearing. CHILD Profile will maintain the partnership with the Infant Toddler Early Intervention Program (ITEIP) to distribute information on hearing milestones in the 3 month, 6 month, 9 month, and 12 month mailings.

### Performance Measure 13: *Percent of children without health insurance.*

#### a. Last Year's Accomplishments

CAH continues to meet with key stakeholders regarding access to health care issues. This includes responding to legislative initiatives to change at-of-consent statutes and other proposals to reduce health coverage of children, teens, and their families. (Fig. 4a, NPM 13, Act. 2)

CHILD Profile inserted the Healthy Kids Now flyer through collaboration with the Health Improvement Partnership. This insert provides information on how to access free or low-cost health insurance for children. (Fig 4a, NPM 13, Act. 1) CHILD Profile health promotion letters referred parents to Healthy Mothers, Healthy Babies (HMHB) to assist them in obtaining medical insurance for their children. (Fig. 4a, NPM 13, Act. 3)

## b. Current Activities

CAH will continue to coordinate with other key organizations and agencies to assure children, teens, and their families have access to health care services, especially health insurance. This will include developing a plan to address CAH's long-term role in addressing this issue. (Fig. 4a, NPM 13, Act. 2)

CHILD Profile continues to insert the Healthy Kids Now flyer through collaboration with the Health Improvement Partnership. The current target population for this flyer is the 4-6 year age group. The Healthy Kids Now insert provides information on how to access free or low-cost health insurance for children. Dissemination of this flyer through CHILD Profile is responsible for 19 percent of total calls received by their hotline, an average of 285 per month (Fig 4a, NPM 13, Act. 1). CHILD Profile health promotion letters refer parents to Healthy Mothers, Healthy Babies (HMHB) to assist them in obtaining medical insurance for their children. (Fig. 4a, NPM 13, Act. 3)

One urban LHJ used assessment data to better address the needs of children without health insurance, and provided free services to a limited number of uninsured clients.

## c. Plan for the Coming Year

CAH will continue to coordinate with other key organizations and agencies to assure children, teens, and their families have access to health care services, especially health insurance. This will include developing a plan to address CAH's long-term role in addressing this issue. (Fig. 4a, NPM 13, Act. 2)

CHILD Profile plans on continuing to disseminate the Healthy Kids Now insert in the health promotion mailings to provide parents with information on how to access free or low-cost health insurance for children. (Fig 4a, NPM 13, Act. 1) CHILD Profile health promotion letters will continue referring parents to Healthy Mothers, Healthy Babies (HMHB) to assist them in obtaining medical insurance for their children. (Fig. 4a, NPM 13, Act. 3)

*Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

## a. Last Year's Accomplishments

The CSHCN Program's Child Health Intake Form (CHIF), the statewide database for children served by Title V, contains data on individual children, including their source of health insurance. In calendar year 2002, data indicated that 42 percent of the children had Medicaid coverage; however, 39 percent were unreported as to insurance source. In March of 2003, the CSHCN Program's contractor, Strategic Services, conducted CHIF trainings for local CSHCN Coordinators to improve the quality and completeness of data, including better information about the source of insurance for each child served. (Fig. 4a, NPM 14, Act. 1)

During 2003, approximately 30 percent of Medicaid eligible children received dental services. (Fig 4a, NPM14, Act 2)

HMHB responded to 15,968 calls related to child health during 2003 to provide referrals and/or information regarding Medicaid eligibility, WIC, or other requested information.

Over 41,000 Medicaid eligible women received Maternity Support Services for a total of 214,814 visits statewide. Maternity Support Services assists pregnant women in obtaining

medical care for their children and newborns through referrals within their local communities. (Fig. 4a, NPM 14, Act. 6)

OMCH contracts with 35 LHJs to provide public health nursing services to families with children, including children with special health care needs. Referrals and assistance linking with Medicaid eligibility and needed medical care are routine services provided by LHJs. (Fig. 4a, NPM 14, Act. 7)

CHILD Profile health promotion collaborated with MAA to assure that Medicaid children received reminders of well-child checkups, immunization information and links to community resources. Every health promotion letter referred parents to Healthy Mothers, Healthy Babies (HMHB). HMHB provided outreach, education and referrals to families and children searching for health care services. (Fig 4a, NPM 14, Act. 5)

## b. Current Activities

HMHB implemented a new data system that will allow better tracking of referrals and information provided to callers allowing us to better track the number of families referred for Medicaid or a Medicaid covered service.

MSS continues to serve Medicaid eligible pregnant women and their families throughout the state. Revisions to the program were implemented October 1, 2003 to improve quality of care and contain costs. Revisions include requirements for basic health messages and referrals for prenatal and child health medical care. (Fig. 4a, NPM 14, Act. 6)

Through contracts with LHJs, referrals and assistance linking with Medicaid eligibility and needed medical care are routinely provided. (Fig. 4a, NPM 14, Act. 7)

CHILD Profile, MAA and health plans are determining if and how CHILD Profile can help improve rates for Medicaid children receiving EPSDT screens and immunizations. CHILD Profile health promotion collaborates with MAA to assure that Medicaid children receive reminders of well child check-ups, immunization information and links to community resources. Every health promotion letter refers parents to HMHB which provides outreach, education, and referrals to families and children who are searching for health care services. (Fig 4a, NPM 14, act 5)

Following the Strategic Services training for the CHIF database, calendar year 2003 data was more complete. For 2003, information indicated the 65 percent of the children had Medicaid coverage, with only 11 percent unreported as to insurance source.

## c. Plan for the Coming Year

The MSS program will continue to review referral systems and work toward improving referrals for pregnant women and infants. (Fig. 4a, NPM 14, Act. 6)

LHJs will continue to provide referrals and assistance, linking families with Medicaid eligibility and needed medical care. (Fig. 4a, NPM 14, Act. 7)

CHILD Profile, MAA and health plans continue to collaborate on how CHILD Profile can help improve rates for Medicaid children receiving EPSDT screens and immunizations. CHILD Profile health promotion will continue to collaborate with MAA to assure that Medicaid children receive reminders of well child check-ups, immunization information and links to community resources. CHILD Profile will continue to connect parents to HMHB through the health promotion letters. (Fig 4a, NPM 14, act 5)

Quality checks will be ongoing as the current criteria are utilized for data entry for the CHIF program. Through the contract with the CSHCN Program, Strategic Services will continue to provide consultation and training to local partners in order to improve data quality for all data items, including insurance source for children in the system. Data for 2004 will be included in next year's MCH Block Grant.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

MSS agencies provided 31,191 nutrition visits to 20,061 First Steps clients in July 2002 -- June 2003. In addition, MSS providers routinely refer and link clients to the WIC program. (Fig. 4a, NPM 15, Act. 1 & 3)

MIH worked to reduce tobacco use in pregnancy by working with MAA and the DOH Tobacco program and provided training to 965 MSS providers. (Fig. 4a, NPM 15, Act. 2) See SPM 2, Activity 1.

MIH worked with MAA to reduce tobacco use in pregnancy and produced materials to help providers understand smoking cessation counseling benefit and document services provided. (Fig 4a, NPM 15, Act. 4) See SPM 2, Act. 2, for a description.

The four regional perinatal centers continued to provide outreach education and consultation for health care professionals. Perinatal/neonatal outreach educators met to exchange ideas for improving quality of education/outreach. Prenatal providers and labs in the state were surveyed to assess perinatal Group B Strep prevention strategies, and to help implement the revised CDC guidelines. (Fig 4a, NPM 15, Act. 6)

Perinatal Regional Centers monitored the delivery sites of very low birth weight babies and advocated for delivery at tertiary care facilities. The Perinatal Indicator Report was completed and helped to evaluate regionalization. To be updated on an annual basis hereafter. (Fig. 4a, NPM 15, Act. 6)

MIH staff are working with March of Dimes (MOD) on the Prematurity Prevention Campaign. The purpose of the MOD national campaign is to increase awareness of the issue of Prematurity and its impact, educate pregnant women on the signs of preterm labor, and improve provider risk detection and intervention, and support prenatal care access. MIH will provide technical assistance and consultation by serving on their Steering Committee, which will plan a provider education symposium and stakeholder summit. (Fig. 4a, NPM 15, Act. 7)

b. Current Activities

MSS providers continue to provide nutrition and preventive health education to First Steps clients. Referrals and linkages to WIC are required under the First Steps redesign.(Fig. 4a, NPM 15, Act. 1, 2, & 3)

The MSS performance measure on smoking cessation and pediatric exposure are integrated into the First Steps redesign. (Fig. 4a, NPM 15, Act. 4)

MIH continues to work with MAA to reduce tobacco use by pregnant women. (Fig. 4a, NPM 15, Act. 4) See SPM 2, Act. 2, for a description.

The Perinatal Regional Centers continue to provide education and consultation to health care professionals providing care to high-risk women and newborns. Group B Strep prevention

practices, education, and outreach continue. (Fig. 4a, NPM 15, Act. 5)

The Perinatal Regional Centers will continue to monitor the delivery sites of very low birth weight babies and encourage delivery of these infants in tertiary level facilities. (Fig. 4a, NPM 15, Act. 6)

MIH continues to work with the March of Dimes conducting outreach through the Prematurity Prevention Project. (Fig 4a, NPM 15, Act. 7)

At the community level, LHJs promoted healthy pregnancies resulting in full-term infants by providing services to families with low birth weight infants including parent education and support; monitoring pregnancy outcomes, especially among American Indian women, and working with local tribal health to develop a comprehensive Maternal and Child Health program; and attending the Prematurity Symposium to learn the most current information about premature infants and prevention of premature births.

### c. Plan for the Coming Year

MSS providers will continue to provide nutrition and preventive health education to First Steps clients through referrals and linkages to WIC. (Fig. 4a, NPM 15, Act. 1, 2, &3)

The MSS performance measure on smoking cessation and pediatric exposure will continue as part of First Steps redesign. (Fig. 4a, NPM 15, Act. 4)

MIH will continue work with MAA to reduce tobacco use by pregnant women. (Fig. 4a, NPM 15, Act. 4) See SPM 2, Act. 2, for a description.

The Perinatal Regional Centers will continue to provide education and consultation to health care professionals providing care to high risk women and newborns. (Fig. 4a, NPM 15, Act. 5)

The Perinatal Regional Centers will continue to monitor the delivery sites of very low birth weight babies and encourage delivery of these infants in tertiary level facilities. (Fig. 4a, NPM 15, Act. 6)

MIH will continue work with the March of Dimes through the Prematurity Prevention Project. (Fig 4a, NPM 15, Act. 7)

MIH will work with stakeholders to monitor access to obstetric care through the OB Access Project. (Fig 4a, NPM 15, Act. 8)

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

### a. Last Year's Accomplishments

The OMCH collaborated with the Injury Prevention Program to oversee the implementation of the Youth Suicide Prevention Program (YSPP). The focus of this population-based activity was to establish media awareness campaigns developed by students in selected schools, support gatekeeper training throughout the state, and support communities in developing skills to respond to suicidal youth. (Fig. 4a, NPM 16, Act. 1)

In 2003 the YSPP increased the number of schools participating in the YSPP campaigns 38 to 79 throughout the state; increased the number of 'gatekeepers' trained to a total of 4,400 since the inception of the program in 1995. Also there was an increase in the number of "hits" on the

YSPP Web Site. Anecdotal information of people using the skills learned in gatekeeper training and through school based campaigns that indicate early intervention taking place at the local level.

Due to Washington State's financial crisis, state funding that supports the CDR program was eliminated for the 2003-05 biennium. As of June 2003, 19 of 35 local health jurisdictions are continuing to review child deaths, 9 LHJs are not reviewing deaths at all, and the remaining 7 are either unsure at this time if they can continue or are considering an abbreviated review. (Fig. 4a, NPM 16, Act. 2)

## b. Current Activities

The OMCH continues to collaborate with the Injury Prevention Program. Currently we are implementing an evaluation of the YSPP including data from the Healthy Youth Survey 2002. Other YSPP activities include:

- Providing Youth Suicide Prevention Campaign Tool Kit Trainings for youth and adults in school communities
- Providing technical assistance and support to schools engaged in youth suicide prevention efforts
- Providing consultation on school-based prevention and crisis response planning and implementation
- Providing suicide awareness presentations to parent and community groups
- Maintaining and enhance the YSPP Website
- Disseminating print material at YSPP sponsored events
- Act as a media contact related to youth suicide prevention and intervention

### GATEKEEPER TRAINING

- Assuring that training is provided throughout Washington State for adults who work with youth; assist as needed in the planning, marketing, set-up and delivery of trainings
- Maintaining networking mechanisms for youth suicide prevention trainers (e.g., list serves, web site, meetings, conference calls)
- Providing consultation and technical assistance for trainers to assure quality and performance standards
- Maintaining database of current trainers available in Washington and post to web site

### COMMUNITY DEVELOPMENT

- Developing strategies to promote youth suicide prevention within communities through existing networks and organizations
- Providing communities with consultation on the development and implementation of youth suicide prevention plans
- Providing technical assistance and support to communities already engaged in youth suicide prevention efforts
- Supporting local and state-wide efforts to promote early identification of children's mental health issues
- Working with key stakeholders in potential and current partnerships to advance youth suicide prevention activities and strategies. (Fig. 4a, NPM 16, Act. 1)

OMCH is working collaboratively with the Injury Prevention program at DOH to produce a report entitled "Childhood Injury in Washington State." OMCH expects to maintain the state database on childhood deaths. OMCH will provide technical assistance for whatever local Child Death Review teams are able to continue. The database will continue to list public health activities directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2)

Local health agencies responded to youth suicide by providing gun safety classes at community youth events; providing training for EMTs and other first responders; providing

training to school staff on adolescent suicide issues and behaviors; and, in one county, the LHJ responded to three youth suicides by surveying 250 young people to get ideas for activities and supports that would be useful to teens. They then began sponsoring teen dances, movie nights, a Suicide Prevention Walk, and parent nights to inform parents. They also implemented "Friendly Faces" in which ministers spend lunch time at local schools.

### c. Plan for the Coming Year

The OMCH will continue to work with the Injury Prevention Program to implement the YSPF statewide in support the reduction of the rate of teen suicide. Plans are to continue in the direction as 2003, to gain further momentum in raising awareness of the problem of youth suicide, to train people who work with youth in the skills for early intervention, and to engage communities to address suicide through prevention and early intervention planning and skill building.

The OMCH will assist with evaluating the YSPF program efforts through comparison of Healthy Youth Survey data in schools that the program is present with those schools that the program is not present. This will be a focus of the Injury Prevention Program during the last half of 2004. (Fig. 4a, NPM 16, Act. 1)

## Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

### a. Last Year's Accomplishments

Perinatal Regional Centers were funded to provide professional education, consultation, and transportation of high-risk pregnant women and neonates. Approximately 600 women were transported to one of four regional perinatal centers for high-risk birth and approximately 500 infants were transported from a community hospital to a regional perinatal center for neonatal intensive care. (Fig. 4a, NPM 17, Act. 2)

Perinatal Regional Centers monitored delivery sites of very low birth weight babies and advocated for delivery of these infants at tertiary care facilities. (Fig. 4a, NPM 17, Act. 1) See NPM 15, Activity 6.

Perinatal Regional Centers continued to be funded to provide professional education, consultation, and transportation of high-risk pregnant women and neonates. (Fig. 4a, NPM 17, Act. 2)

### b. Current Activities

Perinatal Regional Centers will continue to monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities. (Fig. 4a, NPM 17, Act. 1) See NPM 15, Activity 6.

Perinatal Regional Centers funding will continue in order to provide professional education, consultation, and transportation of high-risk pregnant women and neonates. (Fig. 4a, NPM 17, Act. 2)

### c. Plan for the Coming Year

Perinatal Regional Centers will continue to monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities. (Fig. 4a, NPM 17, Act. 1) See NPM 15, Activity 6.

Perinatal Regional Centers funding will continue in order to provide professional education, consultation, and transportation of high-risk pregnant women and neonates. (Fig. 4a, NPM 17, Act. 2)

*Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

#### a. Last Year's Accomplishments

Through its contract with the Healthy Mothers/Healthy Babies (HMHB) toll-free line service, OMCH helped respond to 8,133 calls from prenatal clients in 2003. While a large percentage of callers (46.9 percent) reported that they had visited a prenatal provider at the time of their call, 4,315 reported that they had not had a visit to a prenatal provider at the time of the call. If asked their reason for not visiting a prenatal provider, 90 percent reported they had not done so due to financial concerns. HMHB assisted those who were eligible to enroll in Medicaid and/or provided other referrals as needed. (Fig. 4a, NPM 18, Act. 1)

OMCH continued to manage the MSS program and monitor the utilization and quality of services with 93 MSS provider agencies. In state fiscal year 2003, 46,676 pregnant and post partum women received over 214,000 MSS visits. Issues addressed with families include referral for prenatal care and promoting early and continuous prenatal care. (Fig. 4a, NPM 18, Act. 2)

OMCH contracted with 34 LHJs to provide maternal and child health services, which include routine referral and assistance linking with Medicaid eligibility and needed prenatal care. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data was mailed to First Steps providers and included in the Perinatal Indicators report shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

Due to the economic climate in Washington State, case finding and referral capacity within Community Service Offices (CSOs) has decreased significantly. CSOs are a primary avenue for enrollment in MAA and referral to prenatal care for pregnant women. Monitoring and discussions with CSOs, LHJs, and private First Steps agencies were held to identify other mechanisms for facilitating early access to prenatal care. (Fig. 4a, NPM 18, Act. 2 & 3)

#### b. Current Activities

Medical liability insurance rates have increased rapidly and many obstetricians and family physicians are no longer providing ob care in Washington State. MIH is monitoring this situation and its relationship to prenatal care access and availability.

Numerous projects within DOH, DSHS, and other stakeholders are underway focused on prenatal care access in the state. MIH is overseeing the DOH OB Access Project, which will identify available obstetric access information in Washington; prepare a report of what is known about obstetric access in the state and what it means; discuss methods for continued monitoring of obstetric access; and share information with key stakeholders. (Fig 4a, NPM 18, Act. 6)

OMCH contracts with 34 LHJs to provide maternal and child health services, which include routine referral and assistance linking with Medicaid eligibility and needed prenatal care. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data will be mailed to First Steps providers and included in the Perinatal Indicators report shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

Local efforts to increase prenatal care beginning in the first trimester of pregnancy including: Continuing support for the pregnancy information line; providing pregnancy tests; providing referrals to community providers, one of which resulted in 123 referrals to prenatal services; and providing prenatal education to pregnant women who were not eligible for other prenatal support services.

**c. Plan for the Coming Year**

OMCH will continue to contract with 34 LHJs to provide maternal and child health services, which include routine referral and assistance linking with Medicaid eligibility and needed prenatal care. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data will be mailed to First Steps providers and included in the Perinatal Indicators report shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

Based on the OB Access Report completed in current year, MIH will work with DSHS and other stakeholders to monitor access to prenatal care. (Fig 4a, NPM 18, Act 8)

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Monitor every non-military baby born in Washington for appropriate screening, and follow up on those with incomplete testing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contract with pediatric specialists and comprehensive care clinics to provide expert diagnostic and treatment services for infants with abnormal screening results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Update and develop new professional and lay educational information via different venues: website, provider manual, on-site hospital visits, disorder-specific fact sheets, pamphlets, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Determine family eligibility for financial and support services and coordinate through state and county CSHCN programs and medical home.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Purchase and distribute medically necessary formulas and low-protein foods for individuals with PKU and other metabolic disorders.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Collect long-term outcome data to evaluate the benefit of various components of treatment compliance and intervention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Develop a data system linking newborn screening records with hearing screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Contract with CCSN at CHRMC to provide ongoing analysis of available data on children with special needs, including NCSHCN Survey for state-specific analysis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Ensure family representation in policy development through Medical Home Leadership Network (MHLN), WISE, and Family Advisory Network (FAN) contracts with LHJs and other contractors and through ongoing dialogue at CSHCN Communication Network meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Contract with CCSN at CHRMC to provide ongoing analysis of available data on children with special needs, including the NCSHCN Survey and the CAHPS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Support the MHLN and the Medical Home grant through staff involvement and leadership to increase awareness of medical homes statewide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Contract with LHJs for activities that increase awareness of, and access to, medical homes within their communities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Contract with CCSN at CHRMC to provide ongoing analysis of available data on children with special needs, including the NCSHCN Survey and the CAHPS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collect and analyze statewide program information from CHIF and Health Service Authorizations (HSAs) to identify children who have insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate through various interagency forums such as Communication Network, Medicaid Integration Team (MIT), and interactions with managed care plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide limited diagnostic and treatment funds to fill gaps in services for children with the CSHCN Program, including those for undocumented children with special needs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Contract with CCSN at CHRMC to provide ongoing analysis of available data on children with special needs, including the NCSHCN Survey and CAHPS.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Develop and implement policy based on the outcome evaluation from WISE/Pilots regarding community care coordination.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Maintain the network of CSHCN Coordinators and interagency collaborations to provide forums for system improvement that include families as partners; and provide learning opportunities about systems for children with special needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Contract with Neurodevelopmental Centers (NDCs) to support community based collaborations among NDCs, local health agencies, and other partners.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Contract with the University of Washington Adolescent Health Transition Project to provide transition information about federal, state, and community programs and services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Partner with CAH, OSPI, Family Educator Partnership Project (FEPP), DDD, and DVR to enhance transition services and access to them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Contract with the CCSN at CHRMC to provide analysis of available data, including the NCSHCN Survey, on adolescents with special needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Contract with LHJs and others to complete immunization AFIX (assessment, feedback, incentive, and exchange) visits to enrolled private provider sites.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contract with Community/Migrant Health Centers to enhance utilization of the Washington State Immunization registry in clinic practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Fund a collaborative statewide WIC/IP workgroup and "Immunization Record Roundup" Project in selected counties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Partner with LHJs to conduct population-based surveys to assess immunization levels of two-year-olds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Contract with federally recognized tribes to help build capacity to assess immunization coverage rates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Send parents age-specific reminders of the need for well-child checkups				

and immunizations via CHILD Profile Health Promotion.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Maintain and increase the number of health care providers participating in the CHILD Profile Immunization Registry to improve access to historical records and use the system's immunization recommendation schedule.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Provide abstinence education services for teens and families through four community-based projects.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Contract with the Teen Aware project at OSPI to fund teen-generated media campaigns on abstinence at public schools.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provide fourteen youth development projects for family planning services and/or community-based teen pregnancy prevention services to teens aged 10 ? 19 years.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Collect data to inform the development of a statewide public awareness campaign regarding Abstinence Education (Ab-Ed) targeting youth ages 10 ? 14 years and parents.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Develop, pilot, and evaluate Ab-Ed based media literacy curriculum for youth in 5 sites.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Select, fund, and evaluate 3-5 sites for the teen pregnancy prevention project that incorporates community-based interventions with a family planning component.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Implement and monitor the Ab-Ed based statewide public awareness campaign targeting youth and parents.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Expand use of the media literacy curriculum for youth to other sites and continue evaluation.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Continue funding and evaluating sites for teen pregnancy prevention project contingent on funding and satisfactory work.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Design and conduct periodic statewide sample ?Smile Surveys? (next in 2005).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Review Medicaid and ABCD data on provision of sealants through annual consultation with DSHS Medical Assistance Administration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Offer Oral Health funding to all LHJs through MCH Consolidated Contracts; LHJ activities may include support for and referral to sealant programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Monitor and review the implementation of SSB 6020 (enacted 2001),				

which expands ?scope of practice? for application of sealants and fluoride varnishes in school-based oral health programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Provide parents of children 0 to 6 years with car seat/booster seat information and resources via CHILD Profile Health Promotion Materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Promote the use of car seats/booster seats and other motor vehicle safety activities by several LHJs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Review all unexpected deaths (including motor vehicle crashes) of children 0 ? 18 to by local Child Death Review teams to identify community prevention strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Conduct surveillance of motor vehicle crash deaths to children through the Child Death Review process and disseminate aggregate data and/or prevention recommendations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participate in the Harborview Injury Prevention Research Center?s 3 year grant (2004 ? 2006) to improve the injury prevention capacity of local public health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Collaborate with injury prevention programs outside MCH such as Safe Kids State Coalition and DOH cross-divisional Injury Prevention Workgroup.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Provide breastfeeding support and education to low income women on Medicaid through MSS (First Steps).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide training for MSS providers in breastfeeding support and teaching techniques.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Recommend lactation support at all hospitals with delivery services through a Perinatal Level of Care document.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collect PRAMS data that measures breastfeeding rates, trends, and disparities between groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Develop an EHDDI tracking and surveillance system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Conduct annual newborn hearing screening survey with birthing hospitals across the state.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Contract with CHRMC to promote universal newborn hearing screening in birthing hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Collaborate with Medical Home Resource Teams to promote universal newborn hearing screening and educate Washington State health professionals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Provide parents of children 0 ? 6 years with information about how to access health care via the CHILD Profile Health Promotion Materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Participate on committees addressing children?s access to health care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Use CSHCN CHIF data to identify the percent of children in the CSHCN Program with Medicaid coverage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Review Medicaid data from DSHS MAA showing numbers of children who received dental services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide outreach, education, and referrals through HMHB to families and children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Make MSS provider referrals for newborn and pediatric care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Refer eligible families to Medicaid services through LHJs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Monitor prenatal weight gain and provide preventive health education through MSS providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Increase smoking cessation referrals during pregnancy through MSS Tobacco Initiative.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Improve nutrition and weight gain for infants through MSS and Infant Case Management provider referrals to WIC program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Promote the Smoking Cessation benefit for pregnant women through OMCH collaboration with MAA.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide education and consultation to health care professionals in management of very low birthweight infants and high-risk pregnancies through Regional Perinatal Centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Monitor delivery sites of very low birthweight babies and advocate for delivery of these infants at tertiary care facilities through Perinatal Regional Centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Collaborate with March of Dimes on prematurity prevention campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Collaborate with stakeholders to monitor access to obstetric care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Continue to collaborate with the DOH Office of Injury Prevention to implement and evaluate the Youth Services Prevention program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

2. Work with local Child Death Review teams to review all unexpected deaths (includes suicides) of children ages 0 ? 18 years to identify community prevention strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Evaluate Youth Suicide Prevention Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Monitor delivery sites of very low birthweight babies and advocate for delivery of these infants at tertiary care facilities through Regional Perinatal Centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Fund Regional Perinatal Centers to provide professional education, consultation and transportation of high-risk pregnant women and neonates.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Provide outreach and education through HMHB to pregnant women to increase early enrollment in prenatal services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue MSS provider referrals to prenatal care if clients are not already enrolled; support women to stay in prenatal care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue LHJs provider referrals to prenatal care if clients are not already enrolled; support women to stay in prenatal care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Share prenatal care utilization data with MSS and perinatal providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D. STATE PERFORMANCE MEASURES**

**State Performance Measure 1: *Decrease the percent of pregnancies (live births, fetal deaths, abortions) that are unintended. (Pop. Based, Maternal/Infant, Risk Factor)***

**a. Last Year's Accomplishments**

The MSS Family Planning Performance measure, designed to increase referrals to family planning services and the use of birth control of First Steps clients, has been in effect for three years. Based on reporting of the MSS Family Planning Performance Measure, approximately 58 percent of MSS clients who delivered in SFY 03, or 14,034 women, received health education, clinical support and referral for post-pregnancy family planning services. These visits promoted healthy pregnancies and positive birth and parenting outcomes for the Medicaid population (Fig. 4b, SPM 1, Act. 1).

In coordination with MAA, updated family planning training was provided to over 749 MSS providers during the First Steps regional meetings. More extensive, day long, family planning trainings were offered in two sites to 52 new MSS providers in FFY 03 (Fig. 4b, SPM 1, Act. 2).

Please see narrative under NPM 8 for activities related to teen pregnancy prevention.

In 2003, OMCH's CHILD Profile program continued to include a message about birth spacing and family planning in CHILD Profile Health Promotion materials. The message continued to be placed in the 30-day post partum and the 3 month letters being sent to at least 90% of the annual birth population of approximately 80,000. This activity targeted women of childbearing age who have delivered a baby and reside in Washington State (Fig. 4b, SPM 1, Act. 8). As of September 30, 2003, more than 887,000 health promotion materials have been sent to parents statewide.

Clarification to strengthen MSS agency expectations regarding provision of family planning education and outreach was included in the MSS reapplication process (Fig. 4b, SPM 1, Act. 1).

Reports were shared with First Steps providers showing family planning performance measure progress by agency (Fig. 4b, SPM 1, Act. 5).

PRAMS data on unintended pregnancy was shared with First Steps providers and incorporated into the Perinatal Indicators report shared with the Perinatal Advisory Committee (Fig. 4b, SPM 1, Act. 6).

**b. Current Activities**

The Family Planning Performance Measure will be integrated into a standardized charting system for documentation as part of the First Steps redesign (Fig. 4b, SPM 1, Act. 1).

MSS providers will be offered updates on family planning information (Fig. 4b, SPM 1, Act. 2).

CHILD Profile: In 2004, OMCH's CHILD Profile program will continue including a message

about birth spacing and family planning in CHILD Profile Health Promotion materials. The message will continue to be placed in the 30-day post partum and the 3 month letters being sent to at least 90% of the annual birth population of approximately 80,000. This activity targeted women of childbearing age who have delivered a baby and reside in Washington State. In addition, through a partnership with the CFH Women's Health Network. CHILD Profile will develop a post-partum booklet that includes birth spacing and family planning information (Fig. 4b, SPM 1, Act. 8)

Reports will be shared with First Steps providers showing family planning performance measure progress by agency (Fig. 4b, SPM 1, Act. 5).

PRAMS data on unintended pregnancy will be shared with First Steps providers and incorporated into the on-going Perinatal Indicators report shared with the Perinatal Advisory Committee. (Fig. 4b, SPM 1, Act. 6)

A number of counties used one or more of the following strategies to decrease the percent of unintended pregnancies: Conducting ongoing assessment of pregnancy intendedness to guide policy and outreach activities; establishing a Teen Pregnancy Prevention Taskforce; conducting an assessment project that concluded that school-based health clinics had contributed to a decreased teen birth rate; and providing family planning services to increase access.

#### c. Plan for the Coming Year

MIH will continue to include Emergency Contraception information in its medical meeting display to increase provider awareness and promote pre-exposure dissemination. (Fig 4b, SPM1, Act X).

MSS providers will be offered updates on family planning information (Fig. 4b, SPM 1, Act. 2).

In 2005, OMCH's CHILD Profile program will continue including a message about birth spacing and family planning in CHILD Profile Health Promotion materials. The message will continue to be placed in the 30-day post partum and the 3 month letters being sent to at least 90% of the annual birth population of approximately 80,000. This activity targeted women of childbearing age who have delivered a baby and reside in Washington State. In addition, through a partnership with the CFH Women's Health Network. CHILD Profile will develop a post-partum booklet that includes birth spacing and family planning information (Fig. 4b, SPM 1, Act. 8)

Reports will be shared with First Steps providers showing family planning performance measure progress by agency (Fig. 4b, SPM 1, Act. 5).

PRAMS data on unintended pregnancy will be shared with First Steps providers and incorporated into the on-going Perinatal Indicators report shared with the Perinatal Advisory Committee (Fig. 4b, SPM 1, Act.

### State Performance Measure 2: *Increase the percent of pregnant women abstaining from smoking.* (Pop. Based, Maternal/Infant, Risk Factor)

#### a. Last Year's Accomplishments

MSS Tobacco Initiative to increase smoking cessation among low-income women on Medicaid implemented a performance measure on for July 1, 2003. Reducing smoking in the home and automobile is also addressed in the intervention. Comprehensive training on motivational interviewing techniques, health education materials, and information on community resources

was held statewide. Over 1000 First Steps and WIC providers were trained by June 2003. (Fig. 4b, SPM 2, Act. 1).

In 2003, CHILD Profile sent information on smoking cessation resources to parents of children 0 to 6 years of age. Specifically, CHILD Profile included smoking cessation messages in the SIDS brochure sent at birth, the 1-month, 3 month and the 4.5-year letters (Fig. 4b, SPM 2, Act. 5).

In collaboration with DSHS, the statewide Perinatal Advisory Committee (PAC) and other health care professionals, MIH complete a best practice booklet for prenatal care providers. Smoking Cessation During Pregnancy: Guidelines for Intervention includes information on using motivational interviewing techniques, dealing with relapse, developing quit plans, expanded pharmacotherapy, and additional resources. The booklets were disseminated at major medical education meetings, First Steps trainings, MCH Regional meetings, and at Regional Perinatal Centers educational events. (Fig. 4b, SPM 2, Act 2+3)

MIH continued to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits and professional websites. Through reports provided by MAA, MIH tracked benefit billing data to evaluate how many providers are billing for the intervention (Fig. 4b, SPM 2, Act. 2 and 4).

PRAMS data on tobacco was shared at the First Steps/WIC tobacco training. (Fig4b, SPM 2, Act 6).

#### b. Current Activities

MIH continues to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits and professional websites. Through reports provided by MAA, MIH is tracking benefit billing data to evaluate how many providers are billing for the intervention (Fig. 4b, SPM 2, Act. 2 and 4).

CHILD Profile continues to send information on smoking cessation resources to parents of children 0 to 6 years of age in their SIDS brochure sent at birth, the 1- month, 3 month and the 4.5- year letters. (Fig. 4b, SPM 2, Act. 5).

The MSS smoking cessation performance measure will be integrated into a standardized charting system for documentation planned as part of the First Steps redesign. Provider training will continue (Fig. 4b, SPM 2, Act. 1 and 2).

MIH in collaboration with DSHS MAA, and the DOH Tobacco Prevention and Control Program is implementing a tobacco pilot project for 10 First Steps agencies. This project will provide additional motivational interviewing and systems change training; follow up site visits, and other technical assistance. Training and follow up should be completed by June 30, 2004. (Fig 4b, SPM2, Activity 7 (new)).

MIH is working with the DOH Tobacco Prevention and Control Program to develop and implement a fax back referral system for pregnant women through the state tobacco quitline. This would be phased in with various prenatal care providers starting summer 2004. (Fig 4b, SPM2, Activity 8)

Many public health nurses attended Tobacco Cessation Training to work with pregnant clients. Local health conducted other tobacco avoidance activities, including: Screening clients for second hand smoke exposure and making referrals to the Quit Line, developing bulletin boards and promoting articles in local newspapers; and developing tracking systems to use for assessment purposes.

### c. Plan for the Coming Year

MIH continues to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits and professional websites. Through reports provided by MAA, MIH is tracking benefit billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2 and 4)

CHILD Profile will continue sending information on smoking cessation resources to parents of children 0 to 6 years of age in their SIDS brochure sent at birth, the 1- month, 3 month and the 4.5-year letters). CHILD Profile and MIH plan on collaborating to create an informational flyer for women that will include smoking cessation information. (Fig. 4b, SPM 2, Act. 5)

The MSS smoking cessation performance measure will be integrated into a standardized charting system for documentation planned as part of the First Steps redesign. Provider training will continue. (Fig. 4b, SPM 2, Act. 1 and 2)

Continue working with the Tobacco Prevention and Control Program to implement and market the fax back referral to First Steps agencies and medical providers. (Fig 4b, SPM 2)

## State Performance Measure 3: *Increase percent of women who receive counseling from their prenatal health care provider or tests for identifying birth defects or genetic disease. (Direct Health Care, Maternal/Infant, Risk Factor)*

### a. Last Year's Accomplishments

Washington State Genetics Minimum Data Set reveals that over 6,300 families received prenatal diagnosis genetic counseling through the Regional Genetic clinic system in calendar year 2003. This was approximately a 23% increase over last year. (Fig 4b, SPM 3, Act. 3)

In addition, PRAMS data are collected that ask women if they recall their prenatal care provider discussing "doing tests to screen for birth defects of diseases that run in your family". The most current PRAMS data available are for 2001 and show that 88% of women were counseled by their providers about birth defects or genetic disorders. This figure is not significantly different than in past years. (Fig 4b, SPM 3, Act 4) These data assist the genetics program in identifying effectiveness of outreach and education aimed at providers to increase genetic screening.

March of Dimes Genetic Testing Pocket Facts were sent to Medical Home Teams and to all primary care providers in Washington. (Fig 4b, SPM 3, Act. 2)

The State Board of Health and Department of Health rules pertaining to prenatal diagnosis and counseling requirements for health care providers offering pregnancy related services were reviewed and revised as of May 2003. The rule changes reflect advances in technology as well as standards of care as they related to screening and testing of fetuses and counseling of parents. All health care practitioners offering pregnancy related services received notification of these rule changes.

### b. Current Activities

Support for Regional Genetics Clinics and compilation of their data using the Washington Minimum Genetic Data Set (Fig 4b, SPM 3, Act. 3), as well as monitoring of PRAMS data related to genetic services. (Fig 4b, SPM 3, Act. 4)

Brochures about genetic screening continue to be included in the Healthy Mothers, Healthy Babies (HMHB) educational packets distributed to women contacting the toll-free service.(Fig 4b, SPM 3, Act 1)

A Peer Review meeting for genetic counselors is being planned to increase knowledge about the genetics of hearing loss (etiology, risk assessment, genetic testing, etc). (Fig 4b, SPM 3, Act. 5)

### c. Plan for the Coming Year

The Genetic Services section will continue to support services through the RGCs, compilation of data (the Washington Minimum Genetic Data Set, Fig 4b, SPM 3, Act 3) as well as PRAMS (Fig 4b, SPM 3, Act. 4) to monitor prenatal diagnosis educational trends and continue to support HMHB for distributing educational brochures through their mailings. (Fig 4b, SPM 3, Act. 1)

## State Performance Measure 4: *Establish a sustainable strategy for assessing the prevalence of children with special health care needs. (Infrastructure Building, CSHCN, Capacity)*

### a. Last Year's Accomplishments

The CSHCN Program contracted with the Center for Children with Special Needs at Children's Hospital and Regional Medical Center (CHRMC) to analyze hospital discharge data about prevalence and disparities. (Fig. 4b, SPM 4, Act. 1)

A preliminary work plan was initiated to develop a publication entitled, "Painting the Picture," consolidating Washington State CSHCN data sources. Title V stakeholders including local CSHCN Coordinators, contractors, WISE Grant members, MCH and new partners were consulted on the development and were included in the dissemination plan.

The WISE Grant Integrated Task Force developed a tool to collect information from participating state agencies that collect data on children with special needs. Completion of the document by all agencies was not accomplished. (Fig. 4b, SPM 4, Act. 2)

Our contractor Strategic Software provided statewide training and software distribution to all local health jurisdictions for the Windows version of the Child Health Intake Form (CHIF), the data collection tool used by CSHCN Coordinators. By developing a user-friendly tool, the first step in quality improvement of the data was initiated. The training was preceded by a survey of staff asking for criteria they use to determine when to include a child in the database. Further focused discussions were held at the trainings about uniform criteria statewide and draft guidance was prepared for review and comment early in the summer, and finalized in early fall.

Five local health jurisdictions continued to work with the CSHCN Program and our contractor CHRMC to develop and refine CSHCN County Profiles utilizing existing local data sources. (Fig. 4b, SPM 4, Act. 3)

In 2003, CHILD Profile collaborated with MAA, Snohomish Medical Home Leadership Network Team and UW Center on Human Development and Disability (CHDD) to pilot dissemination of the Ages and Stages Questionnaire (ASQ) to parents of children 18 months of age in Snohomish County. Results of the pilot were compiled and analyzed to determine the feasibility of disseminating the ASQ statewide.

The CSHCN Program continued to identify data systems beyond the public sector to learn

more about the prevalence and needs of children with special needs. Included in this plan was outreach to private insurance plans, Basic Health, the undocumented and the uninsured population. (Fig 4b, SPM4, Act. 4)

#### b. Current Activities

Work was finalized on hospital discharge data regarding disparities among children admitted for chronic conditions. Information about chronic illness was utilized in county profile reports developed under the contract with CHRMC. (Fig. 4b, SPM 4, Act. 1)

"Painting the Picture," a publication containing Washington state data sources on children with special needs, was drafted and the plan for dissemination to our state stakeholders and other states is being finalized. Plan for next steps will be integrated in the 2005 work plan of the CHRMC contract. (Fig. 4b, SPM 4, Act. 2)

Although new procedures for the Child Health Intake Form were not required to be instituted until January 2004, year end data from local health jurisdictions for children served in 2003 has been greatly improved with more complete data reported on each child. Feedback to Coordinators congratulating their efforts is being provided. (Fig. 4b, SPM 4, Act. 3)

CHILD Profile and partners are reviewing the results of the pilot dissemination of the Ages and Stages Questionnaire (ASQ). Initial results of this pilot identified 2.8% of Snohomish County children as having a possible delay. (Fig. 4b, SPM 4, Act. 4)

The CSHCN Program collaborated with a managed care organization, the Community Health Plan of Washington (CHPW), to promote identification of children with special needs. CSHCN Program staff presented information about our state's CSHCN Program and the data from the National CSHCN Survey at CHPW's 2004 Partnership Meeting which included their clinical providers. A new collaboration with Group Health has sparked interest in developing identification strategies for children with special needs in their existing data systems to determine prevalence within their pediatric population and develop strategies to improve service delivery.

Local efforts to better inform decisions about services for children with special needs included producing reports for the community about their children, including children with special needs; following up on a parent questionnaire if developmental concerns were noted; and expanding data collection to learn more about children being served.

#### c. Plan for the Coming Year

CSHCN has been provided with data analysis of the hospital discharge data and will discontinue this contracted activity. Efforts will be directed to utilizing the WISE Grant's systems assessment in order to develop strategies for cross systems integration of data. Maternal Child Health will begin planning for internal data integration in preparation for linking data sets with other agencies serving the same population. The results from the system assessment will guide the recommendations and timing for further cross agency data integration. (Fig 4b, SPM4, Act. 1)

CSHCN will contract with CHRMC to create a data publication that provides a comprehensive picture of children with special health care needs in Washington state, both locally and statewide, using National CSHCN Survey, county profiles, and results of other MCH/CSHCN assessment activities.

Individual county profiles will be disseminated to all local health jurisdictions to assist in describing the population of children with special needs in their community. Technical

assistance on ways to introduce a profile in the community or program will be provided. (Fig. 4b, SPM 4, Act. 2)

Continuing improvement will be fostered in the Child Health Intake Form data through ongoing individual training of local health staff by the CSHCN Program's contractor Strategic Services. Additional programming will also be considered to improve the system. (Fig. 4b, SPM 4, Act. 3)

In 2005, Snohomish Medical Home Leadership Network Team and partners will use results from the pilot dissemination of the Ages and Stages Questionnaire to determine the feasibility of disseminating the questionnaire statewide.

Opportunities for additional collaborations with managed care plans and other agencies and entities with a source of potential data about children with special health care needs will be pursued. Adolescent health needs and concerns and possible data or information that can be aggregated through the Child and Adolescent Health Program's activities will also be a focus of collaboration for the CSHCN Program. (Fig 4b, SPM4, Act. 4)

**State Performance Measure 5: *Reduce the rate of youth using tobacco products.***  
*(Population-based, Child and Adolescent health, Risk Factor)*

**a. Last Year's Accomplishments**

In 2003, OMCH continued to participate on the Joint Survey Planning Committee (JSPC) to oversee the development of the Healthy Youth Survey (HYS). The HYS included questions on health behaviors, risk and protective factors, and assets. The HYS was administered in October 2002. The state report was released in Summer 2003. Other members of the JSPC include the DOH's Tobacco Prevention and Control Program (TPCP), the Office of Non-Infectious Epidemiology, OSPI, DASA, DSHS, and CTED. The HYS was developed in order to reduce the burden to schools and assure all state and local agencies get data a variety of health-related topics, including use of tobacco products by youth. This effort is crucial for the needs assessment process for the adolescent population. (Fig. 4b, SPM 5, Act. 1)

OMCH continued to implement the Teen Health and the Media website. This project is part of a plan to use media literacy as a prevention activity. Tobacco use prevention is one of the topic areas. (Fig. 4b, SPM 5, Act. 2)

Several LHJs reported using Tobacco Youth funding for anti-tobacco activities.

**b. Current Activities**

The OMCH continues to participate on the JSPC to continue planning, recruitment, and training for the 2004 HYS. The OMCH is also coordinating the development of a state plan to address adolescent health issues with the TPCP.

OMCH no longer partners with TPCP to implement the Teen Health and the Media website. The TPCP experienced a budget reduction and cannot support the website. Media literacy continues to be an effective population-based public health strategy to address adolescent health for the OMCH. The TPCP provides information and content for the website. (Fig. 4b, SPM 5, Act. 2)

Local efforts to reduce the use of tobacco by young people included providing elementary school and tribal health fair presentations; and teaming staff from oral health and tobacco programs to provide information to children, preschool through 6th grade.

### c. Plan for the Coming Year

The OMCH will continue to collaborate with the TPCP on the HYS, the development of a state adolescent health plan, and the Teen Health and the Media website. (Fig. 4b, SPM 5, Act. 2)

*State Performance Measure 6: Increase the percent of women who are screened for domestic violence during their prenatal care visits. (Infrastructure Building, Maternal/Infant, Process)*

### a. Last Year's Accomplishments

In 2003, OMCH and our partners continued efforts to increase perinatal provider awareness of domestic violence and to increase provider screening and referrals. Accomplishments included: trained 450 providers across the state on domestic violence screening; developed and distributed "Domestic Violence and Pregnancy: Guidelines for Screening and Referral (DVPG) Booklet; successful collaboration with Washington State Coalition Against Domestic Violence (WSCADV) on writing two grants to support Project Partnership, a pilot study with statewide perinatal trainers and DV Advocates to promote and train health care providers on the DVPG Booklet and increase provider referrals to DV agencies; staffed Perinatal Partnership Against Domestic Violence (PPADV) which produced presentation panels for exhibits at professional conferences (9) and 6 training workshops on domestic violence and pregnancy; distributed 25 PPADV training curriculums to new trainers; continued technical assistance to LHJs, community clinics, hospitals. "The Washington State Perinatal Partnership Against Domestic Violence: Improving Systems of Care for Pregnant/Post Partum Women in the Asian and Pacific Islander (API) Community"(MCHB/SPRANS Grant awarded in 2000 is in final stages. The grant was designed to develop processes that promote culturally relevant screening/ intervention strategies in the API community in year one and two. Year three was designed to pilot a TA Guide to test project successes. A no cost extension was granted to April 2004. During 2003, the final evaluation was completed for the clinical aspects, the technical assistance guide was developed and reviewed by four community clinics. A new project "Healthy Relationships" was initiated to work on promotion of Healthy Relationships for Teens to reduce dating violence.

### b. Current Activities

The MCHB/SPRANS Grant no cost extension continues until April 2004. The Perinatal DV Identification Services Guide (PDVIS Guide) has been revised to include changes from review and pilot sites. A dissemination plan will be developed to distribute the Guide within Washington State. Presentations on the Guide are scheduled from April 2004 to December 2004. (Fig. 4b, SPM 6, Act. 1, 2, 4, and 5)

Strategies aimed at increasing screening/intervention and referral by providers include:

- \*Project Partnership: Pilot Project to establish four Regional DV Liaisons to promote provider screening and referral outlined in DV Booklet.
- \*Continue to distribute PPADV Curriculum to new trainers through the WSCADV.
- \*Continue to provide technical assistance support to hospitals, doctors and clinics for establishing/improving protocols, tool develop and intervention strategies for pregnant and postpartum women.
- \*Continued distribution of the DVPG Booklet to perinatal providers serving pregnant postpartum women.
- \*Revise the Domestic Violence and Pregnancy Facts Sheet to reflect 2001-02 PRAMS data.
- \*Promotion of the provider materials from the PDVIS Guide.
- \*Consulting with the successful applicant for the revision of the PPADV Curriculum to address

all victims of violence in a medical setting (CDC Violence Prevention Funding)

\*Promoting MCH DV projects at professional conferences.

\*Review PRAMS data for changes in DV prevalence (physical and emotional) and provider screening practices.

Local health efforts to increase the percent of women who are screened for domestic violence during their prenatal care visits include: Extending domestic violence services to the community health services center for Hispanic families; providing parenting classes; providing education about drugs, alcohol, and domestic violence; and tracking information in data systems.

### c. Plan for the Coming Year

Strategies for 2005 include:

\* Continuing to promote the PPADV Curriculum (Fig 4b, SPM6, Act 7)

\* Continuing to promote the PDVIS Guide materials (Fig 4b, SPM 6, Act 5)

\* Continuing partnership with WSCADV to write grants (Fig 4b, SPM6, Act 3)

\* Continuing Project Partnership (Fig 4b, SPM 6, Act 2)

\* Continuing Healthy Relationships (Fig 4b, SPM 6, Act 8)

\* Maintaining PPADV Advisory Committee with more inclusive membership (Fig 4b, SPM 6, Act 2)

\* Promoting universal screening through distribution of the DVPG Booklet (Fig 4b, SPM 6, Act 5)

\* Reviewing PRAMS data for 2003-04 for changes in prevalence and provider practices(Fig 4b, SPM 6, Act 6)

*State Performance Measure 7: Increase capacity of OMCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services. (IB, All pop., Capacity)*

### a. Last Year's Accomplishments

MCH funding was allocated for a Child Development Specialist to focus on the mental health needs of the MCH population. The Child Development Specialist began work in March 2003 in the Child and Adolescent Health Section. This position will work closely with the OMCH internal work group and with interagency work groups. (Fig. 4b, SPM 7, Act. 1, 2, and 3)

The internal OMCH Mental Health work group met throughout the year to coordinate, identify, and plan activities across OMCH. The work group provided technical assistance and served in an advisory capacity to the Child Development Specialist. (Fig. 4b, SPM 7, Act. 1 and 2)

An initial mental health promotion plan for OMCH has been developed, including a work plan for the Child Development Specialist and a work plan for the MCH Mental Health work group. MCH mental health planning was coordinated with other MCH planning efforts including the Early Childhood Comprehensive Systems Grant and the adolescent health plan. The Child Development Specialist gathered information from national reports and other state's mental health planning processes to inform this effort.

DOH staff participated in the Northwest Children's Mental Health Symposium in December 2002. DOH provided leadership and technical assistance for an inter-agency group resulting from this symposium to continue to work on this issue. (Fig. 4B, SPM 7, Act. 2 and 3)

OMCH solicited additional resources to assist with mental health assessment. An application

was submitted for a CDC Public Health Prevention Service fellow. The application was not accepted.

Following the December 2002 symposium, MCH worked with the Washington Health Foundation to bring together state, local, public, and private partners to begin to identify issues, coordinate of services, and plan for the future of children's mental health in Washington State. This group is called Partnerships for Supporting Children's Mental Health. They are looking at children's mental health across the continuum of health promotion, prevention, intervention, and treatment of mental health issues. Partners include the Division of Mental Health in the Department of Social and Health Services, Region X Health Resources and Services Administration, and OSPI. The information gathered by this group has informed the MCH planning process. (Fig. 4b, SPM 7, Act. 2 and 3)

#### b. Current Activities

The Child Development Specialist position in the Child and Adolescent Health section continues to look for opportunities to promote children's mental health in OMCH activities and with external partners. This position also works to coordinate OMCH mental health activities with related planning efforts, including the Early Childhood Comprehensive Systems Grant and the adolescent health plan. (Fig. 4b, SPM 7, Act. 1, 2, and 3)

The internal OMCH Mental Health work group continues to meet to coordinate, identify, and plan activities across OMCH. The Work Group provides technical assistance and serves in an advisory capacity to the Child Development Specialist. The Child Development Specialist and OMCH Mental Health work group are collecting and analyzing information from plan implementation. They are using this information to revise the plan and seek additional information as needed. (Fig. 4b, SPM 7, Act. 1 and 2)

DOH continues to participate in the interagency work group Partnerships for Supporting Children's Mental Health. This group is identifying current activities, barriers, and needs related to children's mental health and children's social and emotional well being in Washington State.

The Child Development Specialist represents DOH on the Department of Social and Health Services' Children's Mental Health Workgroup, working with the Division of Mental Health, Children's Administration, Juvenile Rehabilitation Administration, OSPI, tribal representatives, providers, and family members to develop recommendations for more effective and coordinated children's mental health services across DSHS divisions. (Fig. 4b, SPM 7, Act. 3)

MCH is again soliciting additional resources to assist with mental health assessment, planning, and implementation via a CDC Public Health Prevention Service fellow.

Local health efforts for this performance measure include: Participating on community mental health advisory groups to ensure the mental health needs of children are represented; incorporating mental health needs for teen moms in a federal grant application based on the results of a maternal depression survey; offering mental health services to children; and using information from a multi-year assessment to show that students with access to clinical services and increased connection to adults reported improved mental health, less violence, and less stress.

#### c. Plan for the Coming Year

The Child Development Specialist position will continue to look for opportunities to promote children's mental health in OMCH activities and with external partners, and to coordinate with related internal and external planning efforts. (Fig. 4b, SPM 7, Act. 1, 2, and 3)

The internal OMCH Mental Health work group will continue to meet to implement MCH mental health promotion strategies. The Child Development Specialist and OMCH Mental Health work group will continue to collect data and analyze information from plan implementation and use this information to revise the plan and seek additional information as needed. The work group will continue to provide technical assistance and serve in an advisory capacity to the Child Development Specialist. (Fig. 4b, SPM 7, Act. 1 and 2)

CHILD Profile plans to begin incorporating the issues and preventive measures identified by the Mental Health work group in CP health promotion letters on social and emotional development. The Talaris Research Institute will partner with CP to revise and distribute four of their "Spotlight" pieces. These pieces include information on social and emotional development and will be sent to parents of children birth to six years old in Washington State.

The Child Development Specialist and the OMCH Mental Health work group will present process development and strategy at state and national conferences.

Partnerships for Supporting Children's Mental Health, the interagency work group, will continue to meet to identify issues and opportunities for coordination of services and planning for the future of children's mental health in Washington state. Ideas and information will continue to be shared between this group and the OMCH Mental Health work group. (Fig. 4b, SPM 7, Act. 1, 2, and 3)

**State Performance Measure 8: *Increase percent of women screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans. (IB, Maternal/Infant, Process)***

**a. Last Year's Accomplishments**

During 2003, 766 health care professionals received substance abuse screening training from Perinatal Regional Centers, 210 of which were physicians or midwives. The cumulative number trained from January 2000 through December of 2003 is 4,694 professionals, including 1,113 obstetric providers. This training is part of MIH's ongoing efforts to improve provider substance abuse screening skill and effectiveness and increase the number of women identified in need of treatment and referral. (Fig. 4b, SPM 8, Act. 3)

OMCH worked with Medicaid to reduce tobacco use by pregnant women. See SPM 6, Act. 2 for a description of this work. (Fig. 4b, SPM 8, Act. 5).

PRAMS data was collected and analyzed with a new question on provider screening rates for smoking, alcohol, violence, illegal drugs, HIV, and birth control. (Fig. 4b, SPM 8, Act. 7)

MIH conducted eight key informant interviews with obstetric providers in the state to determine effective strategies for influencing and improving screening and intervention for prenatal substance abuse including tobacco cessation and violence screening. Protocol for the four focus groups was finalized. Focus groups were completed by December 31, 2003. (Fig. 4b, SPM 8, Act. 2, 3, 5, and 7)

MIH provided best practices materials and training to providers to improve the skill and effectiveness of substance abuse screening (Fig. 4b, SPM 8, Act. 2 and 3).

The "Screening and Management of Maternal HIV Infection" best practice booklet was revised, printed, and disseminated. The new version has information on the new Washington Administrative Code (WAC) for HIV testing during pregnancy as well as updated treatment regimes. MIH continued to inform providers regarding the WAC changes and their

responsibilities. (Fig. 4b, SPM 8, Act. 4)

MIH continued to work with provider groups to improve the skill and effectiveness of smoking cessation intervention by obstetric providers. (Fig. 4b, SPM 2, Act. 3)

#### b. Current Activities

MIH has completed focus groups with obstetric providers in Washington to determine effective strategies for influencing and improving screening and intervention for prenatal substance abuse (including tobacco) and violence. Four focus groups, two in-person and two by phone, were conducted in October and November 2003. A total of 36 providers participated in this research which was completed in December 2003. Physicians were most interested in practical, concise information for themselves and their office staff. MIH is now developing a work plan of effective strategies for 2004-2005. (Fig. 4b, SPM 8, Act. 2,3,5,7)

The Maternal and Infant Health section, in collaboration with HIV/AIDS program, Northwest Family Center, University of Washington School of Medicine, Children's Hospital and Regional Medical Center, and the Northwest Regional Perinatal Program developed "Guidelines for Management of HIV + Pregnant Women Birthing in Washington Hospitals." These checklists for hospitals and prenatal providers outline appropriate in-hospital care including lab tests and medications for laboring mothers and their newborns. This effort is in response to several episodes when community hospitals did not have the appropriate medications available when a HIV positive pregnant woman presented in labor. These yellow laminated checklists are available for posting and as word documents that can be individualized and placed in the medical record. Dissemination will be through the Regional Perinatal Programs, DOH website, and at medical conferences. (Fig. 4b, SPM 8, Act. 4)

Continue to distribute "Screening and Management of Maternal HIV Infection" best practice booklet. MIH is continuing to inform providers about the WAC changes and their responsibilities. (Fig. 4b, SPM 8, Act. 4)

MIH continues to work with MAA and provider groups to increase the use of the Medicaid Smoking Cessation Counseling Benefit. (Fig. 4b, SPM 2, Act. 2)

MIH continues to work with provider groups to improve the skill and effectiveness of smoking cessation intervention by obstetric providers. (Fig. 4b, SPM 2, Act. 3)

#### c. Plan for the Coming Year

MIH will continue to provide best practice materials to providers to improve the skill and effectiveness of substance abuse screening. (Fig. 4b, SPM 8, Act. 2 and 3)

MIH will implement strategies identified in the strategic planning process that are aimed at providing professional education and improving provider screening skill and effectiveness. (Fig. 4b, SPM 8, Act. 3, 5, and 7)

MIH will continue to inform medical care providers about HIV testing during pregnancy and disseminate the best practice guide. (Fig. 4b, SPM 8, Act. 4)

MIH will continue to work with MAA to reduce tobacco use by pregnant women. See SPM 2, Act. 2 for a description. (Fig. 4b, SPM 8, Act. 5)

*food security. (IB, All pop., Process)*

**a. Last Year's Accomplishments**

Data from the 2003 BRFSS and other indicators of hunger and food security were compiled to understand and clarify the extent and consequences of food insecurity in the Washington state MCH population. (Fig. 4b, SPM 9, Act. 2)

The impact of increased participation in the Food Stamp Nutrition Education Program and the Summer Food Service Program were evaluated. (Fig. 4b, SPM 9, Act. 6)

A contract was established with the University of Washington to guide the development of an MCH food security strategic plan. A collaborative working relationship was established with the Washington Anti-Hunger Nutrition Coalition (AHNC), which is closely affiliated with the Children's Alliance, a non-profit statewide organization dedicated to reducing food insecurity. AHNC, OMCH, and other stakeholders met to identify challenges and potential priority food security objectives for OMCH using a nominal group process. Five themes for potential objectives emerged: Access, Data/Reporting, Advocacy/Education, Organization/Coordination, and Improvements to WIC. Many of these are related to and supported by the data reviewed and analyzed.

The Community Wellness and Prevention section at DOH released a Washington State Nutrition and Physical Activity Plan in June 2003 that includes a reduction of hunger and food security as one of its nutrition objectives and priority recommendations. MCH will take advantage of the launch of this plan and work with CWP.

**b. Current Activities**

Implementing objectives and priorities as developed from the partnership meetings with OMCH, the Office of Epidemiology, the Washington State WIC Program, Nutrition and Physical Activity Section of CWP, the AHNC, and others.

Continuing data analysis of the 2003 BRFSS and advocating for repeating the core set of six validated questions on hunger and food security for inclusion as state specific questions for the 2005 Behavior Risk Factor Surveillance System. (Fig. 4b, SPM 9, Act. 2 and 4)

Local agencies respond to the needs in their communities by providing nutrition consultation to children with special needs and participating on community feeding teams, moving WIC services to the local health department to provide on-stop shopping, providing WIC information at community and tribal health fairs, providing language interpreters to WIC clients, and providing nutrition education to Hispanic women with diabetes.

**c. Plan for the Coming Year**

Maintain partnerships and mutual commitments to address hunger and food security in the Washington state MCH population.

Mobilize resources to identify an OMCH food security lead.

Monitor data sources and indicators of hunger and food security to evaluate trends.

**State Performance Measure 10: *Increase statewide system capacity to promote health and safety in childcare. (IB, Children, Capacity)***

## a. Last Year's Accomplishments

OMCH implements this performance target through a program called Healthy Child Care Washington (HCCW). MCH continued to contract with all LHJs in Washington state to provide Child Care Health Consultation (CCHC). Infrastructure building and population-based services focus on the needs of infants and toddlers, social and emotional behaviors, emergency preparedness, and exploring the role of public health in early care and education. Contracting with LHJs for CCHC work, and keeping up-to-date on best practices in CCHC is an ongoing activity. (Fig. 4b, SPM 10, Act. 1)

The OMCH Child Care Health Consultant continued to provide training, technical assistance and consultation to each LHJ, mainly through phone contacts and regional meetings and trainings. (Fig. 4b, SPM 10, Act. 2)

OMCH engaged in exciting collaborations with early childhood partners and the Office of Superintendent of Public Instruction to address the role of health and early learning. The STEPS State Team worked collaboratively to focus on early learning issues. (Fig. 4b, SPM 10, Act. 3)

HCCW and partners successfully completed a pilot project of the Evaluation Plan for the statewide child care health consultation system. Based on a HCCW-specific theory of change and logic model, this evaluation plan collects data on the following four progressive outcomes: increased institutionalized systems; increased use of skills and standards for CCHCs; increased direct service providers' use of practices that promote a child's social, emotional, physical, health, and cognitive skills; and improved communication between child care providers and parents about child care quality and developmental or behavioral challenges. The pilot successfully showed outcome-based results. The recently designed HCCW Data Collection (HCCWDC) web-based application also underwent a pilot project to evaluate and make recommendations about the efficacy of the system. This project was completed in conjunction with evaluation efforts. (Fig. 4b, SPM 10, Act. 4)

HCCW, Head Start, and CHILD Profile identified steps to form a pilot project in Eastern Washington to determine the benefits and outcomes of CCHC's ability to access the Immunization Registry and to address the immunization status issues of children in and out of home care. (Fig. 4b, SPM 10, Act. 5)

## b. Current Activities

HCCW continues to maintain a CCHCs in each LHJ and to focus on infrastructure and population-based activities. HCCW continues to identify core competencies for a statewide training plan for CCHCs based on best practices and quality improvements recommended from the evaluation plan. (Fig. 4b, SPM 10, Act. 1, 2, and 4) A state-level CCHC continues to provide training, technical assistance, and consultation to each LHJ through regional trainings. New training modules are being developed on emerging best practices for various health issues, most recently Physical Activity and Decreasing Screen Time. A one-day seminar is planned for June 2004 to bring together CCHCs and early childhood experts. (Fig 4b, SPM 10, Act 2)

HCCW facilitated its initial, mandated transition into the broader Early Childhood Comprehensive Systems (ECCS) grant by making staffing changes. One staff member is now dedicated to the ECCS grant, while the other has taken over the CCHC work with HCCW. The work of ECCS aims to influence statewide efforts to build a comprehensive early childhood system across all state agencies. Building on systems and policy work of HCCW, ECCS has begun to expand partnerships inside DOH as well as with new and existing external stakeholders in order to broaden its scope in early childhood. ECCS has also hired a consultant to assist with the creation of a strategic plan and to design an evaluation plan to

clarify and articulate the public health role in early childhood. (Fig 4b, SPM 10, Act 3)

HCCW is focusing efforts on statewide implementation of its evaluation plan for the CCHC system, which includes data collection in the web-based application to track outputs, indicators, and outcomes as identified in the HCCW logic model. One of two new data collection tools was launched statewide and the other is planned to be in use statewide this year. The evaluation data collection tools are designed to provide continuous quality improvement based on the following four progressive outcomes: increased institutionalized systems; increased use of skills and standards for CCHCs; increased direct service providers' use of practices that promote a child's social, emotional, physical, health, and cognitive skills; and improved communication between child care providers and parents about child care quality and developmental or behavioral challenges. The web-based HCCWDC system is also in use statewide. (Fig 4b, SPM 10, Act 4)

The immunization registry pilot project in Grant County, launched by HCCW Head Start, CP, and other early childhood partners, is underway. The plan is to evaluate the success of the project, determine the lessons learned, and make recommendations for potential expansion to statewide implementation. (Fig 4b, SPM 10, Act 5)

Local health efforts include providing on-site consultation and training, bi-monthly newsletters to providers, and parenting education through a collaborative arrangement with a childcare facility in a low income housing area.

### c. Plan for the Coming Year

Healthy Child Care Washington will continue to support a Child Care Health Consultant in each LHJ and to focus on infrastructure and population-based activities. This will likely be a challenge due to decreased local funding for LHJs. However, HCCW is committed to keeping a statewide Child Care Health Consultation system. HCCW plans to utilize its evaluation plan results to modify and enhance the system and to identify core competencies for a statewide training plan for CCHCs based on best practices and quality improvements recommended from the evaluation plan. (Fig. 4b, SPM 10, Act. 1, 2, and 4)

HCCW's state-level Child Care Health Consultant will continue to provide training, technical assistance, and consultation to each LHJ through regional meetings. New training modules will be developed on emerging best practices for various health issues as needed. (Fig. 4b, SPM 10, Act. 2)

HCCW will continue to integrate with the ECCS grant. The HCCW and ECCS Advisory Committees plan to merge into a broader state advisory committee. ECCS plans to identify and create a document for distribution, which details the department's role in early childhood. ECCS will continue to strengthen existing partnerships for early childhood work. ECCS will work to create a strategic plan and to design an evaluation plan for clarifying and articulating the public health role in early childhood. The work of ECCS continues to aim to influence statewide efforts to build a comprehensive early childhood system across all state agencies. (Fig. 4b, SPM 10, Act. 3)

HCCW will focus significant efforts on full statewide implementation of the evaluation plan and will continue to modify the web-based application to be more efficient and user-friendly. Full statewide implementation of the evaluation and data reporting is planned for next year. This will continue our work to reduce duplicative efforts. (Fig. 4b, SPM 10, Act. 4)

The conclusion of the immunization registry pilot project, launched by HCCW Head Start, CHILD Profile, and other early childhood partners, is planned for next year. HCCW will continue to evaluate the success of the project, determine the "lessons learned," and make

recommendations for potential expansion to statewide implementation. (Fig. 4b, SPM 10, Act. 5)

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Decrease the percent of pregnancies (live births, fetal deaths, abortions) that are unintended. (Pop. Based, Maternal/Infant, Risk Factor)				
1. Increase referrals to family planning services and use of birth control through MSS (Family Planning).	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide Family Planning Update training to MSS agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Promote Medicaid Take Charge Program to increase family planning services for men and women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Share progress of family planning performance measure utilization data with MSS providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Use PRAMS data to reference and measure unintended pregnancy rates, trends, and disparities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide pregnancy detection and family planning services through four LHJs.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Include message about birth control and spacing in CHILD Profile messages sent to families.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Increase the percent of pregnant women abstaining from smoking.(Pop. Based, Maternal/Infant, Risk Factor)				
1. Increase smoking cessation among low-income women on Medicaid, through MSS Tobacco Initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Work with MAA to implement the Smoking Cessation benefit for pregnant women. Develop and disseminate provider reference cards.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Disseminate best practice guide for smoking cessation for medical providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Share tobacco data with MSS and perinatal providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide information about and resources for smoking cessation to parents of children 0 ? 6 years via the CHILD Profile Health Promotion Materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Collect and reference PRAMS data to measure smoking rates (prior, during and after pregnancy), quit rates, relapse rates, third trimester smoking trends, and disparities between groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

7. Develop pilot project with additional interviewing and systems change teaching.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Develop FAX back referral system for pregnant women through Tobacco Quit Line.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Increase percent of women who receive counseling from their prenatal health care provider or tests for identifying birth defects or genetic disease. (Direct Health Care, Maternal/Infant, Risk Factor)				
1. Send genetic brochure through HMHB with prenatal mailings.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Send informational mailings to obstetric providers about prevention or testing for birth defects or genetic disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Collect and analyze data from the Regional Genetic Clinics minimum dataset.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collect and reference PRAMS data to measure percent of women offered genetic testing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Establish a sustainable strategy for assessing the prevalence of children with special health care needs. (Infrastructure Building, CSHCN, Capacity)				
1. Contract with the CCSN to analyze annual hospital discharge data in order to assess prevalence and disparities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contract with CCSN to provide ongoing analysis of available data on children with special needs, including the NCSHCN Survey and CAHPS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Standardize the criteria for the CHIF electronic system between all LHJs and neurodevelopmental contractors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop alternative strategies to promote identification of children and youth with special needs in existing data systems and/or surveys of governmental and private entities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Reduce the rate of youth using tobacco products. (Population-based, Child and Adolescent health, Risk Factor)				
1. Participate with DOH Tobacco program in the administration of the Healthy Youth Survey.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop a statewide Adolescent Health Plan that includes tobacco use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Increase the percent of women who are screened for domestic violence during their prenatal care visits. (Infrastructure Building, Maternal/Infant, Process)				
1. Update and distribute Washington State Domestic Violence and Pregnancy fact sheet to all health care providers and professional groups on domestic violence screening and intervention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to offer technical assistance and training to health care providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue grant to address culturally relevant screening in API community and expanding to community clinics statewide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Distribute safety cards to providers statewide.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Distribute handbook on domestic violence for all perinatal care providers in Washington State.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Collect and reference PRAMS data to measure rates of domestic violence prior, during and after pregnancy and percent of women who had domestic violence discussed during prenatal care and number of women screened for domestic violence prenatally.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Promote PPADV curriculum.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Develop Healthy Relationships project.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

7) Increase capacity of OMCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services. (IB, All pop., Capacity)				
1. Integrate mental health capacity into existing OMCH programs through the OMCH Mental Health Workgroup.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collect information and data related to the need for mental health services in the MCH population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with DSHS Division of Mental Health and others to increase partnering on mental health activities including prevention and early intervention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Increase percent of women screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans. (IB, Maternal/Infant, Process)				
1. Develop and distribute alcohol/drug screening best practice materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Conduct alcohol/drug screening training for health care professionals.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Work with HIV/AIDS program to revise WAC related to HIV testing during pregnancy to make routine and continue to inform providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work with MAA to implement Smoking Cessation Benefit for pregnant women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop and disseminate tobacco intervention best practice guide to providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Collect and reference PRAMS data to measure rates of screening and discussion during prenatal care for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Conduct provider focus groups to identify best methods to educate medical professionals and implement new strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Work with provider groups to improve effectiveness of screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Develop and implement measurable indicators and a strategic plan to improve nutrition status among the MCH population,				



Futures materials and concepts. This included working with the local agencies such as Whatcom County Bright Futures project, child care providers and teen pregnancy prevention programs.

*/2005/*

***In 2004, OMCH collaborated with the UW, the Office of the Superintendent of Public Instruction, and the School Nurse Corps to develop training for school nurses on using the Bright Futures Mental Health materials. OMCH also received additional federal funding to promote the use of Bright Futures materials in Head Start, state preschool, and child care settings. OMCH is working with the Governor's State Head Start Collaboration Project and other child care and early learning stakeholders to implement this project. The OMCH and the UW are working with Family Voices to implement "Family Matters: Using Bright Futures to Promote Health and Wellness for Children with Disabilities." This is a three-year grant funded by the CDC. Washington State is one of the pilot sites.***

*//2005//*

EPSDT. MAA developed a series of charting inserts for health care providers to use in documenting EPSDT exams. The purpose of the chart insert was to improve documentation and completion of EPSDT exams. This need was identified through the yearly review of the MAA Healthy Options Plans. The OMCH provided input into the content and format of the insert forms as well as sites to pilot the forms. ***/2005/ The development of this standardized charting insert enabled CHILD Profile to create a Health and Development card for parents to use in keeping track of EPSDT/Well-Child Checkup information.***

*//2005//*

SIDS Reduction Project with African Americans Project. MIH is contracting with the Tacoma-Pierce County LHJ to promote risk reduction for SIDS in the African American community. Local outreach and education will be provided to First Steps providers, child care, churches, and African American leaders and community members.

First Steps Redesign Project. The MAA and the OMCH have worked in coordination with providers to redesign the First Steps Program effective October 1, 2003. The revisions are in response to budget concerns and a major review of the service delivery model. Goals of redesign were to improve the quality of services; contain expenditure growth; and tie intensity of services to client need. ***/2005/ The redesign included development of Core Services to include client screening, basic health messages, basic referrals/linkages, and minimum level of intervention for identified risk factors. Over the first year of implementation, ongoing evaluation of revisions will occur, a standardized documentation system will be developed, monitoring and training plans will be developed, and group activities will be piloted in three sites across the state.***

*//2005//*

First Steps Outreach Project to Native Americans. MIH is contracting with the Seattle-King County LHJ to assist the state program in providing outreach to tribes in an effort to increase utilization of First Steps among Native Americans. Recommendations from tribal representatives will be incorporated into the First Steps redesign which may include special staffing considerations for rural and tribal communities.

*/2005/*

***Drug-Endangered Children. OMCH staffs are working with a local coalition, including representatives from law enforcement agencies, on possible ways to provide legal protection for drug-endangered children.***

***Living Room Forums. The Genetics Services Section contracted with Publicis Dialogue to conduct 15 informal forums with members of the public to gather qualitative data and opinions about three topics related to genetics. The topics were newborn screening, equity of genetics services, and genetic discrimination. The results of the forums will be used to inform the state genetics plan. The Genetic Services Section is now in the process of analyzing the data.***

***Prenatal Care Collaboration. Maternal and Infant Health, in collaboration with the Tobacco Prevention and Control Program, contracted with Insight Policy Research to conduct focus groups and key informant interviews with OB providers in Washington. The purpose of this project was to determine effective strategies for influencing and improving screening and intervention for prenatal substance abuse (including tobacco) and violence. A total of 36 providers participated in this research that was completed in December 2003. Physicians were most interested in practical, concise information for themselves and their office staff. As a result of this project, MIH is exploring development of a prenatal care collaborative in several pilot sites.***

***OMCH Publications. In 2003, the OMCH distributed a variety of publications addressing issues of importance to the MCH population. These documents were made available in print and on the OMCH internet site to a number of public health stakeholders including state and federal agencies, public health professionals and associations, parent and family organizations, and the public.***

***Below is a list of OMCH publications for 2003:***

***\* MCH Data Report***

***\* Perinatal Indicators Report***

***\* Maternal and Infant Rural Health Monograph***

***\* Child and Adolescent Rural Health Monograph***

***\* Preventing Child Firearm Deaths***

***\* Preventing Child Drowning Deaths***

***\* From Rural to Remote America: Family Health Care in Alaska, Idaho, Oregon, and Washington. This report was a Region X collaborative effort with work done by AMCHP and MCH staffs from Alaska, Oregon, Idaho, and Washington.***

***//2005//***

## **F. TECHNICAL ASSISTANCE**

### **1. General Systems Capacity Issues**

#### **a. CSHCN Program**

OMCH wants to provide training at each of four CSHCN regional meetings to local LHJ providers on how to interview families of children with special health care needs in a way that is culturally competent. One of the benefits of this training would be to improve the quality of data collected from families by local CSHCN providers to include elements of ethnicity, education, and economic levels so information can be used in program development. We need a trainer who could teach culturally competent interviewing strategies related to children with special health care needs and their families.

#### **b. Cultural Competence**

The U.S. Department of Health and Human Services' Office of Minority Health issued standards for Culturally and Linguistically Appropriate Services (CLAS). These standards and the implementation compendium are excellent guidelines for health provider agencies to use to better address the cultural and linguistic needs of the populations served. OMCH (Health Disparities Task Force) is requesting assistance in acquiring training on the implementation of these standards for state and local agency staff.

***//2005/***

#### **c. Performance Measure Targets**

***OMCH seeks technical assistance for training on setting targets for performance measures. The audience for this training would be both assessment and program staff. The training would help us develop the skills to develop realistic targets for the national and state performance measures for the Maternal and Child Health Block Grant.***

#### **d. Integration**

**OMCH needs expert facilitation to focus on intra-agency collaboration to improve the health services system for children and families. OMCH/DOH needs to integrate programs within the agency in preparation for cross-agency collaboration. Families often need services from a variety of state programs, agencies and community organizations, but find the services difficult to locate, navigate, and differentiate. OMCH/DOH is collaborating with multiple state and local agencies and organizations on four goals to make the health system work better for families: a common enrollment/application process for easy entry, care coordination to assist families in defining and meeting needs, cross-agency data linkages for program planning, and opportunities for blended funding to maximize impacts.**

#### **e. Fragile X Education**

**There have been many advances in the area of testing for Fragile X and many are even considering targeted newborn screening. Therefore, an educational conference for genetic service providers is being planned for 2004/2005. Technical assistance funds are being sought to bring a nationally known speaker for this event.**

#### **f. Logic Model Training**

**OMCH has had great success in using logic models in conducting the Five Year Needs Assessment and in developing draft state priorities. Training is necessary for all OMCH staff in order to fully integrate the logic model concepts within OMCH and to provide meaningful discussion with stakeholders as part of the public input process required by the MCH block grant guidance. This training will also be beneficial for staff working with stakeholders, including contractors, to develop successful strategies for community-based change. Technical assistance funds are being sought to pay for this training. Jane Reisman of Organizational Research Services has provided training to staff within DOH, and for consistency, OMCH would continue to receive logic model training through this organization.**

#### **g. Adolescent Health**

**The OMCH needs assistance to collaborate with other state and territorial adolescent health coordinators in order to improve access to national resources and experts on adolescent health. This will improve program development and expertise at the state and territorial level. The MCHB would provide support for travel and per diem to attend an annual meeting and funding or assistance in setting up bridge-lines for conference calls between regions.  
//2005//**

## **2. State Performance Measure Issues**

**/2005/**

#### **a. Nutrition**

**This request relates to SPM 9 for improving the nutrition status among the MCH population. Expert advice is necessary to review the strategic plan and food security activities developed to address nutrition status. A sound review of the strategic plan and activities will aid the MCH Nutrition Team in mobilizing and enlisting partner support to address hunger and food security in the MCH population.**

#### **b. Domestic Violence Prevention**

**PPADV committee members have requested a presentation on the new Domestic Violence and Public Health Booklet published by the Family Violence Prevention Fund and written by Linda Chamberlain. Dr. Chamberlain agrees to present for half a day to the PPADV on this topic. MCH staff would like to set up consultation for state and local MCH staff regarding: PPADV curriculum revisions by Public Health Seattle & King County and State Injury Prevention, evaluating domestic violence training, and developing measures for the effects of child witnessing of domestic violence. Dr. Chamberlain comes from Alaska.**

**c. Healthy Relationships**

**The Healthy Relationships Project would like some technical assistance from other MCH state youth projects. The project staff is exploring options within four different states. The purpose of the TA visit would be to: Review current HR proposals and results from external groups; develop a work plan that would provide direction for activities; and provide guidance. The person selected would be a person who has a project within their state that focuses on prevention of intimate partner violence. This speaker would be invited to present at a MCH Teams meeting.**

**d. Funding for attendance at the Family Violence Prevention Fund (FVPF) Meeting in October 2004**

**The MIH Project "PPADV: Improving Systems of Care for Pregnant Postpartum Women in the API Community" would like to present at the FVPF meeting in Boston, MA in October 2004 on the PDVIS Technical Assistance Guide developed with an MCHB Grant. The total cost for the presentation would be: \$2,000. This would include flight, lodging, meals and registration fees. //2005//**

**3. National Performance Measure Issues**

**a. Decision-Making and Comprehensive Care for Children with Special Health Care Needs**

This request relates to NPM 2 and 3 in the areas of decision-making and comprehensive care for children with special health care needs. On-going leadership and skills development and cultural competence training are needed to ensure that families with children with special health care needs can partner in decision-making, serve as mentors, and participate in comprehensive systems development. OMCH would like to bring a consultant from the National Center for Cultural Competence to provide training related to family leadership for children with special health care needs and parent consultants.

## V. BUDGET NARRATIVE

### A. EXPENDITURES

The State of Washington uses the Agency Financial Reporting System (AFRS) as its accounting system. Throughout the reporting year, direct program expenditure data is entered and tracked by the MCH Budget and Contracts Manager as well as program managers and fiscal coordinators. Aggregated data from this report are adjusted to add overhead costs, which have been entered through the agency allocation system (submitted to and approved by DHHS, Region X). The data from both these sources form the basis for the total expenditure data for the year.

The total expenditure data is entered onto spreadsheets by program. This data is apportioned across reporting forms 3, 4, and 5 according to percentages determined by program managers, staff and local health jurisdictions. Expenditure data is then apportioned to the 30%-30% requirements, and the 10% Administration requirement. This same expenditure data is also apportioned according to percentages designated for Populations Served (Form 4) and Levels of the Pyramid (Form 5). In this way OMCH is able to demonstrate a relationship between expenditures and requirements, Populations Served and Level of the Pyramid.

The results of the above calculations are then entered on additional spreadsheets, which contain historical data. From these latter spreadsheets come the variances for Budgeted FY 03 versus Expended FY 03 and Expended FY 03 versus Expended FY02.

Variances are analyzed and entered in the notes on the electronic spreadsheets.

### B. BUDGET

The Agency Financial Reporting System (AFRS), which contains past, present and future time periods is constrained by the fact that Washington State's biennium runs from July 1 of odd-numbered years through June 30, two years following. The system does not allow for data input into a succeeding biennium until the new biennium has commenced.

*/2005/*

***Previously, Washington State DOH's policy was to recognize federal grant allotments on the first day of the grant budget period, or upon receipt of the Notice of Grant Award, whichever was later. As a result, the AFRS data from the most recently completed fiscal year was used for the MCHBG application.***

***For the biennium 03-05, Washington state implemented a new policy. Federal grant allotments were estimated for the whole biennium and entered in AFRS. Allotments are adjusted to reflect actual awards.***

***With regard to the FY05 MCHBG application, the most recent award amount, FY04, will be used. For FFY05, actual expenditure data for FFY03 has been used.***

*//2005//*

This baseline information is adjusted to reflect known or anticipated funding or category allocations. The budget estimates have been adjusted due to the economic forecasts, which indicate a slow economic recovery for Washington State and decreased state dollars. While it is expected that the MCH program will be able to achieve its maintenance of effort amount and 75% match, declining funding sources has meant that MCH does not anticipate being able to overmatch its federal allocation.

Washington State's Maintenance of Effort is \$7,573,626. For FY05, match will be achieved using state funding as well as Health Services Account (HSA) funding for the Immunization Program. Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. This activity is still in its infancy; therefore, it is impossible to

estimate budget amounts at this time. Should this occur in any significant manner, OMCH expects variances when it reports for FY05.

Washington State's total effort is complemented not only by state and HSA dollars, but by other federal sources, including: Title XIX; a number of HRSA and CDC grants; and DSHS Interagency Agreements.

OMCH ensures that the minimum 30 percent - 30 percent requirement is met through its contracts to provide funding to local health jurisdictions. In order to receive funding they must submit a plan designating at least 30 percent to CSHCN and Preventive and primary care for children. The plan ties related activities to CSHCN and primary and preventive care for children, populations served, and the pyramid. At the state level, these requirements form the basis for allocation of funds across programs. Historical data indicate that OMCH has exceeded this requirement. Using actual data from FY02, OMCH is projecting that 45.8 percent of its budget will be expended on preventive and primary care for children, and 48.8 percent will be expended for children with special health care needs.

***//2005/***

***Using actual data from FY03, OMCH is projecting that 57.93% of its budget will be expended on Preventive and primary care for children; and 32.91% will be expended for Children with Special Health Care Needs. Finally, OMCH is budgeting 7.02% for Title V Administrative costs.***

***//2005//***

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.